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ABSTRACT

The conference reported on in this document provided a forum for identification, discussion, and recommendation of alternative policies and approaches to the involvement of blacks in the health decisionmaking process in the United States. Recorded and summarized are discussions which were held regarding the state of health policy in America, formulation of public policy, process of implementation, the black administrator in the health policy arena, and problems and issues in the financing of health care. Also recorded are reports of the workshops which were conducted on national health insurance, cost containment strategies and their effects on current patterns of health care delivery, effecting health planning strategies in the black community, and the improvement of health services for the black community through alternative health financing schemes. Recommendations developed in the four workshops are presented in a closing report. Conference participants and current National Center for Health Services Research publications are listed. (Author/EB)

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RESEARCH PROCEEDINGS
SERIES

A National Conference on Health Policy, Planning, and Financing the Future of Health Care for Blacks in America

Held at Shoreham
Americana Hotel
Washington D.C.
October 28-29, 1977
Sponsored by
Expand Associates, Inc.
Silver Spring, Maryland

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U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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ABSTRACT

A National Conference on Health Policy, Planning and Financing the Future of Health Care for Blacks in America

EXPAND ASSOCIATES, INC.

This conference provided a forum for identification, discussion and recommendation of alternative policies and approaches to the involvement of blacks in the health decision-making process in the United States. Discussions were held regarding the State of Health Policy in America; Formulation of Public Policy: Process of Implementation; The Black Administrator in the Health Policy Arena; and Problems and Issues in the Financing of Health Care. Workshops were conducted on National Health Insurance; Cost Containment Strategies and their Effects on Current Patterns of Health Care Delivery; Effecting Health Planning Strategies in the Black Community; and the Improvement of Health Services for the Black Community through Alternative Health Financing Schemes. The recommendations developed in the four workshops have been presented to the appropriate committees of Congress and administrative officials for consideration in the development of future health legislation.

PREFACE

It has been well documented that blacks in America suffer appreciably from a lack of adequate health care. This condition continues to exist despite the large sums of money that have been allocated for improvements in the nation's health care delivery system. Most of these funds have gone into improved technology, and have not contributed substantially to improved health care for black Americans and other minority groups.

In an attempt to coordinate health care activities in America, the National Health Planning and Resources Development Act of 1974 (PL 93-641) was enacted. This act, which establishes guidelines for achieving adequate health care for all segments of the American population, still has an uphill battle in accomplishing its intent. One of its shortcomings occurs at the local Health Systems Agency level, where the input of blacks is limited. If the intent of this law is to be achieved, then a national policy which will assure the input of blacks and other minority groups must be established and adhered to.

Also of significance to black Americans are issues concerning the adoption of a national health insurance model. There has been and still is debate among those concerned with the health care status of blacks, whether or not the mechanism for financing such a scheme will be responsive to all segments of the American population.

Because the issues of policy, planning, and financing health care for blacks have been in the forefront over the past few years, Expand Associates, Inc. decided to convene a conference in 1977 that would address these concerns and serve as an initial effort to obtain increased involvement of blacks at the policy making level. The discussions contained within this document represent the proceedings from this important conference, and have been prepared as a record of the thinking of the participants and presenters on the various conference topics.

The format for these proceedings has been adopted for your optimum reading convenience. Each panel presentation begins with a summary of the session, followed by questions and answers from the participants. The text of each presenter follows the question and answer session. The dinner speech of Dr. Roy Schneider and the luncheon speech of Dr. Therman Evans separate the proceedings of the plenary sessions from those of the workshops.

During the conference, each workshop was assigned specific objectives related to its topic, and charged with making recommendations related to those objectives. The recommendations from all four of the workshops have been synthesized to decrease overlap, and have been presented to the appropriate committees of Congress and administrative officials, in hopes that they will be considered in the development of future health legislation. These summarized recommendations appear prior to the workshop reports. The specific recommendations from the workshops, however, appear in the texts from the respective sessions. None of these recommendations contain implementation strategies. Such strategies might be worked out through the consortium or black health lobby which was proposed by two of the workshop groups and supported by the entire body during the closing plenary session. Each workshop report includes its objectives, a summary, and text of the participant interaction.

As these proceedings are read, it is hoped that an increased awareness and knowledge of the future of health care for blacks in America will result. It is further hoped that such information will spur those concerned with the status of health care for blacks to contact their congressional representatives regarding the need to have greater input by blacks at the policy and planning levels, if health care conditions for all segments of the population are to improve.

Grateful acknowledgement is due to Ms. Myrtis Williams of the National Center for Health Services Research, who served as Project Officer for the preparation of this document. Her productive suggestions assisted greatly in the preparation of this report.

Reid E. Jackson, II, Ed.D.

FOREWORD

This conference, entitled *Health Policy, Planning, and Financing the Future of Health Care for Blacks in America,* was convened in response to a need to focus on problems that must be addressed in anticipation of a national health insurance program and equitable access to care for blacks and other medically underserved populations under such a program.

The sponsors believe that if any significant improvement is to occur in the health care situation of blacks, they, and others concerned with the problems, must play a greater role in shaping legislative action to provide for the authorization, implementation, and planning of health programs. Participants included administrators and providers from both government and private sectors, consumer representatives and academicians, representing both the political and operational arenas in health policy.

As part of its commitment to actively encourage the development of health services research, the National Center for Health Services Research is distributing the proceedings of this conference for dissemination to health care researchers and policy makers, to inform them of concerns regarding black and minority health care needs.

Gerald Rosenthal, Ph.D., Director
National Center for Health Services Research
September, 1978

WASHINGTON D.C.
OCTOBER 28 & 29
1977
HEALTH FINANCING
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* At the time this conference was held, Dr. Thompson was with the Howard University School of Business & Public Administration, Washington, D.C.

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INTRODUCTION

Theodis Thompson, Ph.D., Moderator
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Good morning, Ladies and Gentlemen. On behalf of Expand Associates of Silver Spring, Md., I am pleased to welcome you to the first national conference on health policy, health planning, and financing that deals with the future health care of black America. Unfortunately, we, as concerned and dedicated citizens of these United States, cannot say that what would be good as a national health policy for America would be a good national health policy for black America. But we *can* say that what would be a sound health policy for black America would also be good health policy for all America. Therefore, we are here this afternoon and all day Saturday to work toward making the nation aware of the fact that black America will not be ignored in the legislative formulation and implementation of a national health policy. We – all of us – are here to work to ensure that our workshop recommendations do not collect dust on the shelves, or make brighter flames in the incinerators of the office buildings of policy makers. For we are led to believe that the country is in the process of developing a national health policy that will *eventually* eliminate the fragmented, pluralistic, and disorganized system of health care services in this country. We feel that something will be done to release the inflationary pressures on the health care industry. We also feel that there will be something more than *paper* planning for health services on a national basis.

These thoughts lead naturally to consideration of the rationale for this conference. It has been in the conceptual planning stage for over two years. This planning process began when Expand Associates took cognizance of the fact that myriad conferences on health policy focusing on minorities have emphasized the fact that there are significant *negative* health differentials between black and white Americans in such areas as adult and infant morbidity and mortality, malnutrition, chronic and infectious diseases, alcoholism and drug abuse, mental health, and health manpower. But issues of cost and financial management are seldom raised. We plan to put these issues into proper perspective by the end of this conference. I also refer you to the statement by Dr. Reid Jackson, President of Expand Associates, and organizer of this conference:

Many health providers and consumers advocate that every American be endowed with the right to adequate health care. This goal, however, will be difficult to accomplish without an established national health policy which is responsive to all, regardless of race, ethnicity or socioeconomic status. Compounding the problem of establishing a national health policy, has been the belief that improvements in the delivery of health care services are directly related to increased levels of financial support to the total health system. Several studies have shown, though, that increased funding levels for such programs as Medicare, Medicaid, Area Health Education Centers, Community Health Centers, Health Planning and others, have not produced an appreciable improvement in the health care delivered to minorities and the poor, during this decade.

Although a number of efforts have been made to ameliorate the health care situation of blacks, most of these have occurred at the level of program operation rather than program planning. Expand believes that if any significant improvement is to occur, blacks and others concerned with the problems must play a greater role in shaping legislative action which provides for the authorization, implementation, and planning of health programs. Therefore, Expand has convened this conference to identify the many facets of health policy, planning and financing relevant to blacks, to clarify and review the issues in the light of some positive statement of principle, and to develop an analytical basis from which to work for modified or alternative policies. To accomplish this, Expand has assembled administrators and providers from both government and private sectors, consumer representatives, and academicians; these individuals are leaders in the field, representing both the political and operational arenas in health policy. During the plenary sessions, these leaders will provide information; during the workshops, they will assist in the development of strategy. Hopefully, the recommendations coming from this forum will be incorporated into national health policies to be established in the near future. Finally, because blacks are more often the consequence of health policy in its operational phase instead of participants in the formulation and process phases, it is hoped that this forum will create an awareness of the necessity for blacks to formulate policy and participate in the decision-making process from inception to actualization.

In order to create this awareness, and hopefully some positive political action, the following conference objectives have been formulated:

- To develop an understanding of the state of health policy in the United States and its implications for black America;
- To assess the change in trend of health status of black people and minorities, relative to their social political and economic conditions, by analyzing the most current, appropriate, and accurate data available;
- To formulate policy guidelines as to desirable types of health programs and activities in all areas of health and medical care as they relate to blacks;
- To develop and forecast an alternative national health policy statement;
- To plan mechanisms for the improvement of health within the black community, given current and proposed choices;
- To analyze the potential impact of PL 93–641, PL 94–484, and the National Health Services Act, and other legislation on health policy development and implementation for black health care providers, consumers and facilities serving this population.
- To forecast the future of the health status of blacks, based on the long range effects of proposed changes in U.S. health policy, and
- To analyze the effects of cost containment on the provision of health services to the black community.

The objectives for each workshop will be passed out at the beginning of each workshop. The plenary sessions of this conference are to be a review of the state of the art on health policy, planning, and financial concerns. Audience participation is essential to an effective synthesis of all relevant ideas into working recommendations. These recommendations will be disseminated to policy makers, voluntary health associations, governmental agencies, health insurance companies, and to the public for their use in the development and implementation of a national health policy in this country.

There is general agreement that the "health care crisis" in the United States centers on finance. We are experiencing escalating costs, exorbitant capital equipment outlays, Medicare cost over-runs, Medicaid fraud reports, rate and expenditure review – all of which are clearly financial. Moreover, to enact any form of national health payment mechanism without an accompanying national health philosophy and policy statement would be like releasing a bull in a china shop. The slogan that "health care is a right" has financial significance in an economy where resources are scarce, and also has political consequences. It is only when we are healthy and strong in mind, body, and spirit that we may have "life, liberty and the pursuit of happiness."

As we begin this exciting day and a half of intellectual and practical discourse on health policy, planning and financing, I am reminded of one of the many wise sayings of Dr. Martin Luther King, Jr.:

> *One of the difficult lessons we have learned is that you cannot depend upon American institutions to function without pressure. Any real change in the status quo depends on continued creative action to sharpen the conscience of the nation and establish a climate in which the most recalcitrant elements are forced to admit that change is necessary.*

Indeed, there is need for assertiveness in health among the black citizenry.

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CONFERENCE OVERVIEW

Senator Edward M. Kennedy
Democrat, Massachusetts

I am pleased to address this audience of health professionals and consultants on such an important dimension of our national health care policy. The impact of the nation's health care policies on black America deserves special attention. This conference, and others like it, are important vehicles for developing the data necessary to identify the special health care concerns and interests of our minority population. It is a credit to Expand Associates that this forum has been developed at such an important and critical juncture in congressional consideration of national health care policy.

President Carter has committed himself to comprehensive, universal national health insurance. He has set a target date of this spring for the submission of his legislation to the Congress. The Congress is presently reviewing the Administration's cost containment bill. I introduced this legislation in April, and it was passed by the Human Resources Committee in August, with certain important modifications.

Currently, the Subcommittee on Health and Scientific Research of the Senate is reviewing legislation aimed at drug reform and strengthening the Food and Drug Administration. It is also considering legislation to relieve our elderly of the economic burdens of purchasing prescription drugs. The Subcommittee is also considering important changes in our federal approach to biomedical research and health planning.

In the upcoming months, my colleagues and I on the Health Subcommittee will be actively reviewing many of the federally funded programs providing important health services, including migrant and rural health centers, neighborhood health centers, state and local planning mechanisms, human experimentation issues, mental retardation and developmental disabilities, health manpower, and federal funding and appropriations in these and other important congressional legislative initiatives. There are important health items on the agenda of other congressional committees for the upcoming session. In terms of congressional activity, the timing of this conference is excellent.

I am glad that you are in Washington today. I am glad that you are here to provide the nation's health policy-makers with the perspective of blacks in America on how national health policy can better serve the health care needs and interests of this population. You can aid us in isolating what those interests and needs are. You can help us develop alternative mechanisms to address those special concerns within the context of an overall national health care policy.

In Boston, and in Washington, I am told that health policy does not reflect enough black input. I share this feeling that too often, coherent, instructive information of black Americans and their perspectives on important issues is only developed after legislation has been introduced. It sometimes seems as though such important input is accepted only in order to defeat a measure, or to justify overruling an administrative decision. You must feel that the national health policy-makers and legislators too frequently allow you only to react to policy and legislation. I share your concern. This must be stopped. We must find ways to receive your creative ideas before the decisions have been made. There must be more opportunities for cross-communication between policy-makers and black public health and policy analysts and administrators.

This forum today is an excellent opportunity for such discussion. It is an opportunity to begin to turn this trend around and to move in the direction of a new relationship. I am glad you are here, now, before health policy and planning has been finally decided. You are here early enough to help establish the rules of the game. Now is the time to help us develop policy, set the goals, and set the future of health care for the country. Now is the time for you to present your new alternatives, your new models, and your new ideas. Now is the time for a renewal of the commitment of the nation's leaders to the goals of providing quality care and comprehensive health services to all our people.

Just how has our national health care policy affected black Americans? Major public financing of health care began in 1965 with the development of the Medicare and Medicaid programs. These two programs were directed at the two segments of the population believed to suffer from the most severe inequities in access to health care: the elderly (Medicare) and the poor (Medicaid). Since blacks are a disproportionate share of the poor, Medicaid has been a major influence on access to service and the quality of care provided to black Americans.

There has been progress in the provision of health care to these groups since the inception of these national programs. Since these programs began, there has been a marked improvement in the access of the poor to care. And yet, even with Medicaid and Medicare costs rising steadily, there are still problem areas and disparate treatment of blacks and whites, even in these programs.

1) There are significant numbers of the poor ineligible for Medicaid;
2) Medicare payments are higher for whites than blacks;
3) Health services are more extensively paid for whites than for blacks;
4) White Medicaid patients also receive payments for physician services that are 40 percent higher than for blacks.

What can be done about these problems? Can we attribute these differences to racism in the provision of health services? Or can they be attributed to lower incomes and education in blacks as compared to whites? Can there be regional and geographic factors at play?

Yes, we can probably attribute the problems to a continuation of most or all of these factors. However, these problems cannot be adequately and comprehensively addressed by simply expanding Medicare, reforming Medicaid, covering only catastrophic costs or covering only mothers and children. These proposals may accomplish little more than adding dollars onto the federal budget. Simply paying the bills under a national health program will not remove the unequal burdens which we discussed here. What is needed is universal coverage of all Americans under the same health care program, a program which offers comprehensive benefits regardless of income, place of work, age, past medical history, sex, race or any other factor. These benefits should include care in the doctor's office as well as hospital, and emphasize preventive care, early diagnosis, and early treatment.

And yet Medicare and Medicaid alone are simply part of the difficulties. Let me identify some other problem areas demonstrating noticeable health differences between whites and blacks:

- The life expectancy of blacks, especially black males, is still noticeably lower than for whites;
- Obesity in black women is more likely than in white women regardless of age or poverty level;
- The infant mortality rate among blacks is 85 percent higher than among whites;
- Teenage pregnancy and the absence of prenatal care causing infant mortality is higher among blacks than whites;
- Fifty percent of black men between the ages of 55 and 65 have hypertension, as compared to only 31 for whites.

The list could go on. And I know that you know these facts and figures better than I. You see them in the faces of your friends, your relatives, and acquaintances. You see how poverty and unemployment plague black Americans to a greater extent than their white counterparts. You know how nutrition studies, reviews of dental care, and smoking and drinking habits, drug abuse, and the like reveal great differences between the health condition of whites and blacks.

How are these problems being addressed? What mechanisms in our health care system are attacking these glaring discrepancies? I have seen first hand many of the neighborhood health care centers and the ambulatory care clinics in the inner city hospitals where many black Americans receive their health care. I am familiar with the long waiting lines, the sometimes insensitive physicians, and the frustrations caused by high drug prices. I share with you your concern for quality care and fuller access for blacks to the advantages of the nation's complete health care system. I understand your frustration, sometimes bewilderment, at how few services of our enormous health care system are readily available to the poor, to the black, and to the elderly, in comparison to the more affluent.

But we know of successes within that system as well. We have seen the Charles Drew Neighborhood Center in Los Angeles, the Solomon Carter Fuller Mental Health Center in Boston, and Howard University Hospital make great strides in their quest for excellence in servicing the black communities of our inner cities. We have watched with anguish the struggles of Mound Bayou Mississippi Neighborhood Health Center to overcome the problems which plague many such facilities.

And because of these successes, we know that we can address these problems. This nation's health care policy can ensure expanded access to quality health care and preventive and curative treatment to its citizenry, rich and poor, middle income and no income, black and white. This is not, however, an easy time for such reform. Two years ago, I proposed providing additional funds for encouraging and stimulating additional minority medical and other health professional students in our nation's graduate schools within our National Health Manpower Act. This measure passed the Senate, but was dropped in the conference with the House of Representatives.

I need not dwell on the small percentage of black physicians in the country. Nor need I chronicle the desperate shortage of black nurses and allied health professionals. We certainly need more black hospital administrators and managers. Even after our fight for affirmative programs to ensure greater numbers of black physicians and medical students, there are societal forces which are working to erode even this progress and accomplishment. With immunization of children drastically reduced, there is immediate need for action to protect our youth from undetected disease and disability. Senator Ribicoff and I are presently cosponsoring the Child Health Assessment Act of 1977, which will expand the number of children eligible for federally supported health evaluation, hearing and vision testing, and disease screening.

But there are other legislative initiatives that must also be explored and reviewed in order to address the problems I have identified in black health care. We must evaluate ways to:

- Strengthen and support our neighborhood health care centers and the services they provide;

- Strengthen and develop more capable HMOs and state and local health planning boards and agencies;

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- Review our policy and federal commitment to identification, screening, treatment, and research, especially on new antihypertensive drugs, and to federally funded hypertension programs and studies;
- Explore expanding preventive care services such as dental care, prenatal care, and diet and abusive habit counseling.

Until we have one card, which every citizen possesses, where each mother can choose any physician she wishes to provide care for her child, we shall have certain disparity in access to health care and the quality of health care for the poor and the minorities. Until every pregnant black teenager can get the same counseling as white pregnant teenagers, we shall have these problems. Until we control costs and provide the appropriate incentives for the expansion of health care services apart from in-patient hospital facilities, these problems will persist.

Black Americans, like all Americans, are affected by the skyrocketing costs of health care in this country. As taxpayers, or premium payers in third-party plans, or even as one of the 20-to-40 million Americans with no health insurance, public or private, black Americans feel the impact of rising health care costs. Last year our nation spent nearly $140 billion for health care. This is three times the amount spent ten years ago. At the current rate of increase, it has been estimated that without any intervention, health spending will grow to more than $230 billion in three short years. Health care has become so expensive that Americans are now working more than one full month of every year just to pay for their health – two weeks' wages for hospital care alone. We cannot allow this to continue.

Health care should be a right and not a privilege for every American. Long ago we guaranteed a decent education as a matter of right. As a society, we have said a decent education should not depend on whether a family can afford to pay for it, or the color of their skin. We must assure the same for health care. Health care as a right must be a part of the vision we cherish for our people. Health care is basic to a full life in our free society. The freedom and opportunities we offer every American are hollow promises to those whose minds are weakened or whose limbs are twisted by unnecessary illness or deferred care.

Health care must be a right for all in our society and not merely a privilege for a few. Any national health insurance program must be comprehensive in its coverage to all citizens. It should strengthen those entities of health care which serve and service black Americans. It should increase the services in rural and inner city areas. More emphasis must be placed on efficient and effective primary care. Incentives should be provided to support effective, less costly health care while continuing to require the highest quality of care.

Our national health care policy and program must reflect and recognize the special needs of minorities and blacks concerning their health care. I pledge my support and efforts to securing such action in the Congress.

No one could come here today and meet without noticing the enormous continuing tragedy in South Africa, and to recognize that, even though that nation is a long and far and distant way from where we sit here this noontime in the comfortable surroundings of the Shoreham Hotel, and as much as all of us are committed and concerned about the fashioning and the shaping of health policy, we must take note of the tragedy of South Africa, and the violation of the most basic and fundamental human rights that continues in that country. To effect any kind of constructive change in that situation demands the best efforts and concern of all of you here today, and the continued voicing of objections by all of us who have responsibility in the Congress and Senate of the United States.

I welcome the chance to join with you here today. In the time that remains, I would be glad to respond to any of the questions that you might have.

AUDIENCE QUESTIONS & ANSWERS

SENATOR KENNEDY'S ADDRESS

MR.BOWLES: Senator Kennedy, I am Bob Bowles, a post-graduate student at George Washington University Health Care Department. My question concerns the financing of National Health Insurance. I had the privilege to attend a seminar two weeks ago with former Congressman Wilbur Mills, and he said that, before his illness, you and he had agreed on a National Health Insurance program in 1974.

My question concerns the impact of a National Health Insurance program on the American citizen; what do you recommend as the financing mechanism for National Health Insurance? Who would pay for it?

SEN. KENNEDY: I am strongly committed to S.3, the Health Security Act. We propose to build on the Social Security System, as was done with the Medicare program. I believe that that really is the most effective and efficient way to build in terms of the financing aspect; to provide half the revenue from an employee payroll tax and half from general revenues.

Now, the point to make, I think, and to underline in terms of health insurance, is that we're paying $140 billion now. If you look at the cost comparisons that were done on all the various proposed health care programs and health insurance programs by HEW in the fall of '76, you'll find out that the costs are virtually the same. The Hospital Association Bill is actually more expensive than Health Security, by about 8 percent. If we do nothing at all, the Congressional Budget Office says we'll spend between $240 and $250 billion by 1983.

So the thing that we all ought to understand is that we are going at a bankrupt pace for the federal treasury if we do nothing at all; the question is, are we going to try and do something to bring the costs under control? And are we also going to deal with the issues of equity? I think these issues are fundamental and essential in ensuring quality care for the American people.

How are we going to do it? I believe that there is really only one effective mechanism to do it and that's S. 3, or the only one that really would have the effect of providing cost control mechanisms which are essential if we're going to have a workable system. And so I think that that is really the best way to deal with it, but I know that we always get primarily to the question of cost. Can we afford to do it?

I think the first answer is: can we afford *not* to do it? If you look at what has happened in Canada, we're talking about a system which is the closest to what we could probably come to. They have actually limited their health care costs to 7 percent of GNP. We're up to 8.6 percent and climbing. Their principal increase about two years ago was insuring that they were going to pay women as much as they were paying men in terms of all the functions of their health care system. Now, they've been able to achieve that, and they've got real stability. Of course, there are problems in the Canadian system. No one is denying that. But what is not at issue in the Canadian system is the equity and availability of health care to the Canadian people, and that is a fundamental question. You'll hear or you can read about problems, but you go and talk to the people in Canada and you don't get the kinds of complaints or the denials of care that you hear about in our own country.

MR. MARTIN: Jim Martin, Director of Minority Affairs, the Medical University of South Carolina and the State Director of the AHEC Minority Program for the State of South Carolina. In your reference to blacks getting into medical schools, what effect – and I'm sure you've been asked this a thousand times – do you feel that a favorable ruling on the Bakke case would have on blacks entering medical schools, and on other quota systems?

SEN. KENNEDY: Well, I think it is really not useful to try to speculate on that decision. I do feel that unless we are going to have strong affirmative action in terms of minorities in medical schools, in the professional schools, and in all aspects of vocational training then we're going to have the most serious reversal of progress that we've seen since prior to the Brown decision.

But I'm hopeful that the message is very clear. I didn't attend the presentation before the Supreme Court, and I have no reason to have any more information than anyone in this room would have. I think there is an enormous amount at risk, and it is an extremely important watershed decision. I'm strongly committed myself through the legislative process to a strong continuing commitment toward affirmative action in our medical schools as well as in higher education. The interesting part in the Bakke case is that many states for years violated basic human rights, and that was the reason for enacting the 13th, 14th, and 15th amendments over a century ago. And now we have a state that was trying to remedy that situation, and the laws which were passed during that period of time to remedy adverse local state actions are now being used to undermine what I think was a constructive attitude on the part of the state. But I'm hopeful that we won't see a reversal in terms of minority enrollment in medical schools, and I'll do everything I can to deal with it.

DR. FLACK: My name is Harley Flack, and I'm from Howard University. This week I read an article in the *Chronicle of Higher Education* regarding the fiscal plight of Meharry Medical College, which is, as you know, one of the bulwarks in terms of health manpower supply. Being an employee of Howard University myself, I'm quite aware of some of the budgetary problems that we have as traditionally black institutions. Looking around the room here, I see a number of individuals that I know who are either working at traditionally black institutions or have been students at such institutions. Knowing that these schools are major suppliers of health manpower, what is being done or what do you see being done in the future in terms of legislation and policy that would benefit these institutions, to keep them from going bankrupt?

SEN. KENNEDY: There are provisions which are available to those schools and other needy schools in current legislation. But I think it would be extremely difficult to create a special provision in the Health Manpower Bill that would apply only to black medical schools. I may be wrong, but I don't think that's going to fly. I think what we can insist on is that Meharry and others serving vital needs should have resources made available to them.

DR. ALLISON: Senator Kennedy, Lavonia Allison from North Carolina. If, in fact, one of the national concerns is to increase the representation of black health professionals, why not give a bonus to those institutions that are actually making this kind of contribution? They would not necessarily be the historically black medical schools; the bonus program could include any schools that are, in fact, producing significant numbers of black health professionals. The present system seems to be that those who are doing the most get the least.

SEN. KENNEDY: Well, let me say I'm all for you. You get the language up and I'd be glad to introduce it in the Senate. The tragedy is that schools other than the black schools have exceedingly poor records. How are you going to change the formula to say that white institutions that go from an absolutely abysmal situation to an unreasonable situation should get a financial reward?

But maybe that has to be done. Let's get your suggestions and I'd be glad to have you sit down with our people, then, with Joe Onek and some people in HEW and find out what we could do. I'm with you, and I'm sure if we can get some of those people together with the medical educators we could come on up with something. And I'd welcome the opportunity. Greg Spence will be here and Peter Parham would be glad to work with you.

Jim Corman is here. I've looked through the program, and you have a good panel. I just want to thank you very much. I look forward to working with you, and pledge to you my interest in getting input from this conference, and my desire to work closely with you in the future. I think that cooperation offers the best hope for an agenda which is long, difficult and complex, and is going to take the best efforts of all of us here. Thank you very much.

DR. THOMPSON: We'd like to thank Senator Kennedy for those very interesting remarks and for giving us some idea of issues that we should consider in talking about health policy. As we move into the rest of the conference, we will be able to dwell on these issues in more depth.

We should also keep in mind that Senator Kennedy gave us a challenge. Not only should the recommendations from this conference be forwarded to his office and to his subcommittee, but we should also develop additional recommendations and policy proposals to forward to the various congressional committees dealing with the vital issues we will consider for the next two days.

PLENARY SESSION I

TOPIC I: THE STATE OF HEALTH POLICY IN AMERICA

MODERATOR

Theodis Thompson, Ph.D., M.P.A.

Acting Assistant Dean for Graduate Programs,
Assistant Professor of Health Services Administration,
School of Business and Public Administration
Howard University, Washington, D.C.

.................................PANEL.................................

- **Jacquelyne Jackson, Ph.D.**, Associate Professor, Division of Medical Sociology, Duke University Medical Center, Durham, North Carolina.
- **James C. Corman**, Democrat - California, Subcommittee on Health of the House Ways and Means Committee, U.S. House of Representatives.
- **Joseph Onek**, Associate Director, Domestic Council Policy Staff, The White House.
- **Howard Hiatt, M.D.**, Dean, School of Public Health, Harvard University, Boston, Massachusetts.

SUMMARY OF PANEL PRESENTATIONS

TOPIC I: THE STATE OF HEALTH POLICY IN AMERICA

Dr. Jacquelyne Jackson began the session by stating that current public health policies in the United States are fragmented, inadequate in both coverage and comprehensiveness, and powerless to guarantee health care to all black Americans. She called for a comprehensive and effective national health insurance program that will address three specific issues:

- Preventive Care;
- Health manpower; and
- Health norms.

Dr. Jackson further stated that environmental factors such as racism, unemployment or inadequate employment, and poverty are perhaps the most important constraints on good health for black Americans. She also called for a reversal of the decision of the government to admit aliens; they have the net impact of reducing employment opportunities for native - born citizens, many of whom will be and are black. In addition, Dr. Jackson called for the training of more black health educators and health researchers to focus on economic, political, and social health policies. Further she voiced strong opposition to efforts to deny women the right to make their own decisions regarding abortion.

In closing her thought provoking presentation, Dr. Jackson expressed concern over the structure of the U.S. Social Security System and the proposed extension of the mandatory retirement age for many Americans. She would modify that proposal by urging relevant health research to determine what race-specific differentials, if any, should be applied in setting retirement ages for Americans. "In any case, Social Security should not be saved by Americans riding disproportionately long and hard on the backs of dead blacks." Any related research efforts she believes, should have an appropriate portion of the funds allocated to competent black researchers.

Congressman Corman, co-sponsor with Senator Kennedy of the Health Security Act, described their efforts through the Committee for National Health Insurance.

He stated that it is essential for this country to develop a national health insurance plan without any deductibles or co-insurance mechanisms. He expressed his belief that other alternatives to deter overutilization and abuse of the health system by providers and consumers should be identified. Mr. Corman ruled out a national health insurance plan to cover catastrophic illnesses only. In a sense, he said, catastrophic insurance coverage already exists with Medicaid and Medicare. Finally, he suggested that the so-called "Free Enterprise" market does not work for the health care sector of our economy because of the uncertainty of the risks involved, the inadvisability of purchasing some medical services such as tonsillectomies, and the lack of consumer knowledge about what one is purchasing in medical care. Congressman Corman also stated his belief that any form of national health insurance is three to five years away from adoption by the U.S. Congress.

Joseph Onek, President Carter's domestic policy advisor, emphasized the need for a national health policy that would encompass more than a national health insurance plan. Mr. Onek pointed out that health is more than medical care and depends on other federal policies related to housing, nutrition, highway safety, and occupational health. Alleviating health problems due to poor work environments and chemical poisons in the workplace, air and water, is as significant in improving the health of American citizens as trying to get people to stop smoking, he said.

Mr. Onek stated that the Carter Administration will introduce a compulsory, universal national health insurance bill to the U.S. Congress in 1978. He agreed with Congressman Corman that it would be some three to four years before any type of national insurance bill would pass the Congress. Meanwhile, the Carter Administration is preparing a national health policy, according to Mr. Onek, through other proposed legislation. Such legislation includes the Childhood Health Assessment Program, designed to upgrade the Early Periodic Screening, Detection, and Treatment Program under Medicaid; the Hospital Cost Containment Act of 1977; and a Medicaid and Medicare Fraud and Abuse bill. According to Mr. Onek, the Carter Administration is making a major effort to increase immunization levels for polio, measles, and other diseases. Assistance is also being given, he said, to proposed legislation to assure Medicaid and Medicare reimbursement for physician extenders. Participants, as well as other citizens, were encouraged by Mr. Onek to visit, write, and pressure their congressional representatives and other appropriate federal officials.

Dr. Howard Hiatt, Dean of the Harvard University School of Public Health reflected on the state of health policy through examples of the problems in the British National Health Service. He pointed out that even with a national health service, access to health care is a function of social class. Furthermore, he stated, the problems of alcoholism, excessive smoking, poor housing, and unemployment still exist. And he reiterated the observation of other panelists that health care is more than medical care. The most stimulating message in Dean Hiatt's presentation was acknowledgement of need for an effective model to use in the allocation and distribution of scarce health resources. He believes that in order to do more for health care, it is necessary to make decisions about competing alternative uses for resources. Dean Hiatt emphasized the need to work with other groups at the University and community level in order to improve the health status of all citizens.

AUDIENCE QUESTIONS & ANSWERS FOR PANEL I

MR.WICKHAM: Landon Wickham from New York City. My question is basic. Why is there a major change in the timetable for national health insurance? We have been talking at least 10 years.The president has promised a bill within a year. Does the public truly have to get out on the street and walk around with signs saying "We need it now?"

CONG. CORMAN: Well, no, sir, although I would not want to discourage you from doing that. It might be a useful thing. I must tell you that it is not my choice that it is going to be another two or three years. I wish that it were last year. But I am trying to be realistic, and I must say in defense of the administration that I have no criticism of their timetable on when they are sending it to us. I would tell you I would much rather you would send us a good program in March than send us a lousy one in January. But assuming that the President had sent it down in July, the Congress could not have gotten to it. There is no consensus in the House of Representatives, and I suspect there is no consensus in the Senate for national health insurance at this moment; I hope during the next elections that the voters will make their views known to the men and women who seek public office at the federal level in that respect. The President has made a commitment that he will send us his proposal for national health insurance. I expect and I sincerely hope that it will be a universal, compulsory public program. If he does, I do not believe we can get it through the Congress in this next year. He sent us a welfare reform proposal that is very far reaching. It is extremely important to a great many people in this country who border on hunger. I hope we can get that through next year. There is a wide range of other things. But I don't see mechanically how we can do it. I also don't get a sense that there is a strong consensus yet. You can help tremendously in gaining us that consensus in the next Congressional elections.

MS. PILGRIM: My name is Juanita Pilgrim, from Durham, North Carolina. First of all, with national health insurance, I hope you include transportation and outreach for the people who have been without health care all along. National health insurance will not do it if you don't have these two things. Also, we look at cost containment, and we point the finger at the provider, but has anybody stopped to point the finger at the drug supplier, the medical supplier, the equipment supplier? This is where the cost is. The provider is in business to make a living; he has his overhead, and the overhead comes from these sources. So until you attack these sources, you can't blame the provider.

CONG. CORMAN: Well, first of all, in considering the transportation, there will be a great many things that national health insurance will not solve. It will not rehabilitate the slums and ghetto areas of the big cities. It will not solve the transportation needs of rural areas. But it will solve one problem. It will remove the economic barrier between the person who is sick and the doctor. There will be a great many additional things that we must do in addition to national health insurance. Education and distribution of educated people, providing facilities, all of those things will have to be done, too. But don't fault the national health insurance system if it doesn't do everything. Realize that we have to do additional things. Just plain income maintenance support is probably going to prevent a tremendous amount of illness because it will mean that people will not be undernourished; at least we hope it will.

MS. PILGRIM: The other question dealt with supplies and drugs.

CONG. CORMAN: Yes. The story we get from the hospitals right now, because we are trying to get a hospital cost containment law, is "Don't just pick on us." But I do think that if we pick on them, we will see some changes in how they buy and what they buy. We did offer them a rather generous increase, a 150 percent cost of living increase, but again, there are a lot of regulatory things that need to be done. I believe we will be better able to do that if we have a single system so that we funnel resources into the system in a way which give us some bargaining capacity with all of the providers and suppliers. Your point is well taken, and it is something that we tend to forget. We talk about generic drugs a little bit, but I learned from a hospital administrator at home that there is 500 percent difference in price between one kind of X-ray film and another. But the doctor says, "My patients get only the best." Well, maybe it isn't five times better.

MR. LOADHOLT: Congressman, I am interested in the medical profession and the community. I would like to know why is it that Congress doesn't mandate that the community be an equal partner with the administration and the medical profession. Now, we know in the community that doctors and top-heavy administrations are charging exorbitant prices without the community knowing it, but if the community is an equal partner in providing health care, we can deal with the prices they charge in serving communities.

CONG. CORMAN: Yes, sir, your point is well taken. There will be others on your panels who know how the new Health Systems Agencies work. I don't know, but I do know that there is an effort to move in that direction, and certainly we ought to learn from the mistakes we have made so far. We have made a mistake in not involving the community. When we have a national health insurance program, we need to have community input and community assistance in monitoring what goes on.

MS. MILLER: The name is Louise Miller, and I am from Atlanta – Spelman College. Your statements about this compulsory national health insurance concern me because it is going to end up in the same sort of status as Social Security. Not only that, it is going to eliminate the people for whom we are most concerned because the people who are most astute in getting their hands on services will do it. These are the people who will end up, in the last six months of their lives, in intensive care where the greatest costs will be put on the system. These are tremendous expenses, and I don't see them being met unless the people at the other end of the scale will be left in want. What I want to know is what provisions you are making to prevent that.

CONG. CORMAN: Well, first of all, the fact is that the proposed program is universal, and the only way it can be universal is to be compulsory. In other words, we don't anticipate setting up a system where people can opt in or out at will. If we don't make it compulsory, people will drop out when they are well, and drop in when they are sick.

You mentioned Social Security. The only thing seriously wrong with Social Security now is that it is not universal, and we lost that battle yesterday. But unless the coverage is universal, then groups of people will be left out. If it's voluntary, the people who will tend to be left out are wage-earners or people with modest incomes, who have pressures on their discretionary spending, who will decide that since they are not sick, they can't afford the insurance.

That is one of the reasons that I would hope it would be universal. I mentioned that I hope it's comprehensive because, if the only kind of care that is paid for out of the insurance system is intensive care, we will spend a tremendous amount of money on it. But paying for preventive care makes more sense. The routine health check that we take our children in for, the doctor's visit, all of those things need to be paid for, too. That is the way I believe you will get a more rational allocation of resources. Things change slowly, and I wouldn't tell you that overnight there will be a sudden shift away from that intensive care. But if we pay for health care across the board, I think we will be much more apt to get the kind of balance you suggest. If there is no balance, we will have to find some additional ways to do it. I would welcome your suggestions because I think it is important that people get some reasonable amount of care throughout their lives.

MS. WIND: My name is Emma Wind, from Medgar Evers College in Brooklyn, New York. I teach public health nursing there, so naturally my interest is in nursing. With all due respect to paying for physicians' services, I think that at this moment it is time that we include payment for nursing services outside the lump sums for hospital supportive services, as part of any national health policy or national health insurance program which is developed.

We, in our college, are preparing nurses for primary health care. That is to keep well people well through health appraisals that separate the normal from the abnormal, and then refer the "abnormal" to the physician for treatment.

So I think some provision should be made in the policies for reimbursement for nursing service separately from hospital supportive services.

CONG. CORMAN: Thank you very much for your suggestion. That is taken care of, in large part, through Health Maintenance Organizations, but probably needs to be addressed more specifically.

I want to say one more thing because the Bakke case was raised. When the President took office, he met with all the Democratic House members, and he said, "If you ever want to talk to me, just call up." I never had occasion to talk to him until about two weeks ago, since I had talked over the weekend with Andy Young, and I did want to talk to the President. At 8:00 o'clock in the morning, when the switchboard opened, I called, I thought, "I wonder if this really will work." At 3:30 the President of the United States did telephone me and we talked for about 10 minutes about the Bakke case. And as you know, as a result of conversations he had with a number of people over that very early period just before the Attorney General filed the brief, there was a substantial shift in the administration's position.

I have confidence that the President understands the problems of racial discrimination in this country and recognizes that we will have a long, long way to go, and that I was quite pleased that he really does call back a Congressman like he said he would.

MR. LOADHOLT: Congressman Corman, before you leave, I feel like I need to tell you something sir. Take this to the President, the members of the Committee, and get it to the lawyers who presented the brief about the Bakke case. I feel that I need to say this because this Bakke case is not to be taken lightly. It is as paramount in the American way, and has just as much effect on us black Americans as did the Dred Scott decision, the 1954 Civil Rights Act, and Brown versus Topeka, Kansas. What I want you to tell them is that we will not be hoodwinked by the efforts put forth by your state, sir, to get blacks and other minorities into affirmative action. This young man, Bakke, with all due respect, is about to do to the affirmative action programs in America, what busing has done for education of the masses. So let's not let that happen. Take that to them, please.

MR. CRAWFORD: My name is Peter Crawford. I want to make a couple of comments. I suppose they would be directed toward Joe Onek, if anyone in particular.

At least two speakers, Mr. Onek as well as Congressman Corman, indicated that the realization of black aspirations depended very much on our actions at the ballot box. I wanted to remind Mr. Onek that black America demonstrated last November 2nd very much what their aspirations were. Without claiming to speak for all of black America, I would like to share the *perceptions* of many black Americans who are watching the events on the national horizon very carefully, who have seen President Carter apparently back away from his Senatorial supporters on the issue of gas deregulation; who have seen President Carter apparently back away from the $50 tax cut and several other issues; who have seen the necessity for Vernon Jordan and the Congressional Black Caucus having to very forcefully bring to President Carter's attention the problems besetting urban America. And many of us have also seen the lack of the long-awaited urban policy.

My point in reviewing this litany is that black America is dependent very much upon the direction of the President and the actions he takes. Many of us are wondering – and I don't expect you to be able to totally answer this – if, when push comes to shove on health issues, whether Jimmy Carter will do as he appeared to do with the issues of gas deregulation and the $50 tax cut? Now, these are vital issues that beset all of us here, as well as those whom we represent. We have already voted; over 90 percent of us voted last November 2nd that health was a priority whether it was health categorically or health from the standpoint of employment, which is a component of health.

I would like to recommend that this conference consider very carefully the whole range of health issues, in terms of getting a message to the Congress and the President about our concerns.

MS. HERON: Thank you. I would also like to direct my comments to Mr. Onek. My name is Bernice Heron, and I am the President of Physicians' Health Services Plan, a Health Maintenance Organization, in Reading, Pennsylvania. I understand that the administration is very much supportive of HMO development. I would like to point out that all the things we have talked about thus far this morning, our HMO is already doing. However, we are encountering problems with providers and hospitals who are not exactly thrilled with HMO development. So I would like to know if the administration is willing to accept the challenge of encouraging Congress, through legislation, to impose penalties on doctors and hospitals who do not participate in HMO development in their communities?

MR. ONEK: Let me say, first of all, that you are correct that this administration is committed to HMO development. Some of you may have seen yesterday that Secretary Califano announced that he was personally going to urge leading corporations in this country to help sponsor HMOs. The first great HMO, Kaiser Foundation, was sponsored by a corporation. There hasn't been as much interest as there should be. On your point, we do realize that there has been a great deal of discrimination against HMOs in the past by providers. We realize that even under current planning processes, which we support generally, there is the possibility of discrimination, and we are looking into ways of remedying it. One of the things we have done in our own legislation, for example, is that under our Cost Containment Act, HMOs are exempted. HMO hospitals, that is, hospitals which are primarily servicing HMO patients, do not have to meet the same revenue caps as other hospitals because we know they are more efficient. Similarly, when we have capital limitations, we have tried to exempt HMO hospitals. But you are suggesting going further. I don't know the specifics in your community, but I do think that under national health insurance we are going to try to make sure that all the incentives, whether financial or otherwise, are in favor of HMOs and not opposed to them.

MS. HERON: Well, my point is that if national health insurance is going to take two to three years to implement, HMOs are here today, and we are already servicing poor people. Many Medicaid patients are already being served through HMOs. So I think the kind of encouragement we need from the administration is to impose strict penalties against hospitals and doctors who do not encourage HMO development in their communities, and that could be done today.

MR. ONEK: I would suggest that if you could write me on this, with more details of the situation in your community, and some specific suggestions, I would like to see them. I should also say I can't reveal all the legislative plans, but at the moment there are plans which will make it easier for HMOs to serve Medicare and Medicaid patients in the future.

MR. BERRIEN: My name is Charles Berrien. I am a mental health educator with the National Institute of Mental Health. I also represent a group called BRC, which is the Black Reparations Commission. I would like to move this discussion in another direction. In listening to the points that have been made, starting with Dr. Cornely, about alternatives to health care and the lower longevity of blacks, I would contend that, rather than having to deal with another system similar to Social Security, where we will more than likely be paying more for services than what we would get, that it would be more appropriate that blacks should get certain services and rewards as being due in payment for past injustices.

Now I know that the idea of reparations generally makes peoples' hair stand up, but I was wondering if any of you had some kind of feedback on how health care could be included under that area. The Indians have gotten it. The Japanese have gotten it. The United States is demanding reparations from a number of countries because of some industries that they no longer have control over. So it is not a new concept. It is not militant. It's an old established idea, very much used. I was just wondering if any of you have any feedback on that idea.

MR. ONEK: I have no feedback on reparations generally. I would like to point out, and I think Senator Kennedy mentioned this. Under our current system, it is true that even under Medicaid, which serves only poor people, the program seems to be paying more to white beneficiaries than to black beneficiaries. That probably reflects the fact that there are not enough physicians and other providers in areas accessible to black people and other minorities. I do think it is crucial that we have a national health insurance program which doesn't end up providing more benefits, as you suggest, to those who are wealthier, those who happen to live in areas where there are going to be more physicians available.

It goes to the point that national health insurance, a financing mechanism, is only the beginning. As Senator Kennedy and others have said, we have to have adequate manpower available to everybody so that people can make use of the national health insurance card that they will have. I think there is a danger that we will have national health insurance, but like many other programs designed to help those with less resources, they end up helping those who have the most resources, because those people have greater access to the particular facility, whether it is a state university or what have you. But I do think that is a problem that we have to address.

DR. HIATT: I would like to add a word. I will duck the reparation aspect of your question. I think it is one on which I really have no expertise. But I do want to underline what Mr. Onek has just said. It is not only in this country under Medicaid, but in Britain under the National Health Service, that those people who are most in need of services seem least able to use the services they need. Poorer women, after they become pregnant, get to the obstetrician later than middle income or lower middle income women, and that inevitably has traumatic effects. Now, earlier Dr. Cornely mentioned Dr. George Wiley. It seems to me that one major aspect of George Wiley's genius was his capacity to acquaint people with what their rights were. That is certainly one area in which I would hope that there would be a good deal of emphasis in a conference like this. Educating people as to what their rights are, what they are not receiving under current legislation and what they might not receive under the proposed legislation, I think is one task that is going to require the best efforts of all of us.

DR. JACKSON: I think that it is worth noting, in terms of the comparative data about differences in average expenditures for Medicaid patients, that they may not be reflective of differences in terms of seeking services, because they were not controlled for differences in costs. It is my understanding that in a good number of states, many black physicians were caught by the usual and customary fee, so they were not able to raise their fees to the extent that white physicians were, and consequently they are still getting paid less money. So we do not yet know, in my judgment, whether or not there is actual difference in usage. There is actual difference in costs which has to do with discriminatory payments to the providers .

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MR. MARTIN: Jim Martin, Medical University of South Carolina again. I am concerned basically with those things that will precipitate a national health policy, and those are the things that are going on right now, as the young lady mentioned. My question is directed to Mr. Onek. I wonder if the President or Mr. Califano is aware of the results of the Carnegie study in 1972, that created the Area Health Education Centers in 11 areas. I wonder, too, if he is aware of the fact that these areas have been successful in doing some of the things that we are talking about now, and that is to get the health care away from the health centers, out into the rural areas and underserved areas. I am also wondering why it appears to the AHEC people that success is being punished by a cutback on the program. I am also wondering if they are aware that HEW did not even follow the legislation concerning funding patterns for the AHECs for the year. I would like to have your response to that, please.

MR. ONEK: Candidly, I do not know enough about the details of what you are referring to, to respond. Perhaps we can talk briefly after this meeting. But I would suggest, as I suggested earlier, that you write me with the details, and if you have had difficulties in dealing with any people at HEW, please let us know that, as well. I would be glad to go into it with you, but I don't know enough details to go into it here.

MS. MILLER: Louise Miller again. I direct this comment and question to Dr. Hiatt. It appears to me, from all the things that have been said here today, that if this system really were to work, that you get the educational component going so that people are aware of their rights and what good health would really mean to them, and, indeed, they would be able to keep themselves healthy, and in large measure bypass the provider. Now, what does that mean to the providers? It means that, if this works, they are actually going to work themselves out of a job. How do you feel about that, as a physician?

DR. HIATT: It has been said that if people would take action in just perhaps five or six ways, that is, with respect to cigarettes, alcohol, automobile safety, drugs, exercise and diet, they could do more for their health in the long run than this whole complicated apparatus of doctors and hospitals and nurses and specialists that we have. I think we are a long way from that point. I don't see any of my physician colleagues who are really worried about being out of work. It is not an unpleasant prospect. I do think, however, that it is a point well taken in a somewhat different sense. I think that among the people who need education are the health providers: The doctors – and here I will give nurses equal rights – the nurses, and health auxiliaries. I mentioned tonsillectomy before. I think most doctors who recommend tonsillectomy are honest people. I don't think they are looking to do this to make money. They simply need to be educated. You will be interested to know that somebody once looked at the wives of surgeons in the State of California, and found that they had more surgery than wives of other professionals. I think that your point is well taken, that education is required, and it is required in a general sense.

DR. THOMPSON: We must cut off the questions to have a refreshment break. First I will attempt a brief summary. Then those of you who would like to talk to the panelists during the break, please feel free to do so. What we have come to this morning, very quickly, is that the state of health policy in America is more static than dynamic, and it remains a somewhat uncoordinated system. Health is much more than medicine. That has been brought out by the emphasis placed on the need for education, preventive medicine, and environmental health, including housing, employment, and basic education for all. We also talked about another very interesting issue. That is the management and allocation of health resources and how to go about making more intelligent decisions about allocating and managing scarce resources. A key issue was brought out several times; that is the issue of accessibility, which includes not only transportation, but finance and other kinds of related issues. This is an issue which ought to be dealt with very closely in our workshops. We also ought to talk about power. What kinds of power can we muster in determining the proportion of available resources allocated to the black community? I thank you. Let's break for refreshments. We will reconvene at 2:30.

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PLENARY SESSION I

TEXT OF PANEL PRESENTATIONS

THE STATE OF HEALTH POLICY IN AMERICA

DR. THOMPSON: Our first presentor is Dr. Jacquelyne Jackson. Because of her distinguished career, it will not be necessary to describe her accomplishments in detail at this time. But she is known for her work in issues concerning racism in the field of mental health. Dr. Jackson has published in many scientific journals, and is also past editor of the *Journal of Health and Social Behavior.* She has also written extensively for *Ebony* magazine on the subject of black women and their plight. Dr. Jackson is Associate Professor in the Division of Medical Sociology at the Duke University Medical Center. Her specialty is gerontology , with an extensive bibliography on the black aged. She has been a key person in the National Caucus for the Black Aged and is currently a postdoctoral fellow in social epidemiology at the School of Public Health, University of North Carolina at Chapel Hill. We are very pleased to have her with us today.

Our next panel member is Congressman James C. Corman, Democrat, from California. Congressman Corman is Senator Kennedy's colleague and cohort on S. 3, the health security bill. We hope that Congressman Corman will tell us about the status of S. 3 at this time, along with other proposals involving national health insurance. This audience, I am sure, would also be interested to know what we can expect from the House of Representatives in terms of accepting black input into the development of a national health policy.

Our next presentor is Mr. Joseph Onek, Associate Director of the Domestic Council Policy Staff in the White House. He was President Carter's adviser on health matters during the presidential campaign. Mr. Onek has been heavily involved in White House staff activities related to health care issues. We would particulary like to hear from Mr. Onek on what the current administration is planning in terms of a national health insurance program and a national health policy, and about some of the current problems

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with energy legislation and what that may portend in terms of environmental health issues.

The final presentor will be Dr. Howard Hiatt, Dean of the Harvard University School of Public Health. I had an opportunity to hear him this summer when I was participating in Harvard's Program in Health Systems Management. I am sure there are a few others in the audience who have also participated in this program. We hope Dr. Hiatt will bring us up to date on what schools of public health around the country are doing relative to developing a national health policy.

And now the presentations . Dr. Jackson, please.

Jacquelyne Jackson, Ph.D., Duke University Medical Center

DR. JACKSON: Thank you, Dr. Thompson. Expand Associates has assembled us here today to deliberate cogently and sagaciously on the extremely important topic of planning and financing the future of health care for black Americans. My mandated contribution, in addition to being one of the token women selected as program participants, is that of commenting on the state of health policies in the United States as those policies relate specifically to black Americans.

It is no surprise to any of us that the overall state of public health policies in the United States related to black Americans, as well as the overall implementation of those policies, is far from desirable. In general, public health policies in the United States are fragmented, inadequate in both coverage and comprehensiveness, and powerless to guarantee adequate health care to all black Americans. Yet during the past few decades remarkable progress has been made in improving the health care available to black Americans. Without doubt, some of this progress is immediately attributable to the desire to protect the health of Americans who are not black. Thus, we often find significantly greater efforts being made to reduce contagious rather than non-contagious diseases among blacks. Some of us also suspect that greater efforts are being made to reduce mortality among us from specific diseases hardly killing any of us, than from those frequently killing substantial numbers of us. Finally in this connection, many of us are convinced, and correctly so, that the improved health care currently available to black Americans is largely due to our own efforts. Conversely, it is also fair to say here and now that much of the poor health found among many blacks is due to our own inadequacies.

Since I believe strongly that the future of health care for blacks must include comprehensive and effective national health insurance, with appropriate forms of socialized medicine, I wish, in the time remaining, to emphasize certain issues of great concern to me, and, I hope, to you. In no particular order, these issues are:

(1) Health prevention,

(2) Health manpower, and

(3) Health norms,

where, in the latter instance, specific focus will be placed on the crucial issues of the availability of abortion resources and of the minimum age eligibility for primary beneficiaries of OASDHI under the Social Security Act of 1935 and its subsequent amendments.

HEALTH PREVENTION. A careful examination of public health policies, including those attached to Medicaid and Medicare, would reveal considerable gaps in the area of preventive medicine, not the least of which is an explicit definition of the types and frequencies of physical examinations for specific race-sex-age groups. Clearly, the future of health care for blacks must include greater emphasis on preventive medicine in the areas of physical and mental health. At the very least, this means that blacks must demand and receive specific and comprehensive coverage for routine physical examinations from highly qualified health personnel under national health insurance, which means, of course, that blacks must work harder to get the kind of national health insurance which is most appropriate in meeting their specific needs. It means that as much emphasis should be placed on prevention as on treatment. It also means that blacks must recognize more clearly in the years ahead that they are not members of minority groups *per se*, but that they constitute a specific minority group, different in some important respects from all other minority groups. It also means that blacks must become ever more cognizant of environmental constraints on good health. Perhaps the most important of such constraints for blacks today are, or are related to, racism, unemployment or inadequate employment, and poverty.

In this context, it is surprising to me that our national black leaders– or so-called black leaders–have typically been silent about the crucial issue of the continuing admission–illegal or otherwise–of aliens to the United States. It seems to me, a humble, natural-born citizen, that this conference should go on record as opposing the President's plan to provide, in effect, short-term and long-term citizenship to aliens. Such a plan will have the net impact of further reducing employment opportunities for our native-born citizens, many of whom will be and are black. I believe that passage of the Humphrey-Hawkins Full Employment Bill will have little impact in improving employment opportunities for blacks as long as too many aliens are admitted readily and steadily to the United

States. Health prevention also means that we, as blacks, must become even more concerned about such issues as the pandemic problem of venereal andrelated diseases. We must cease worrying ourselves about racial discrepancies in the reporting of these diseases, and we must help find the best ways to prevent them in the future. Health prevention for blacks also means that we must cease giving medicine too much credit for good health. Even substantial increases in the availability of physicians, dentists, and related personnel to blacks will probably not result in significant decreases in our health problems until, and unless, we are willing to take care of our own health. In the final analysis, we must be the guardians of our health, and that of our family members. Thus, an effective national health insurance policy must include adequate provisions for health education, which brings us to the subject of health manpower.

HEALTH MANPOWER. I have, I hope, already implied that blacks must be concerned about health manpower beyond the usual discussions of parity in the physician ratios between the black and non-black populations. It seems to me that much greater emphasis must be placed on the development of a wide range of health manpower, including indirect and direct professionals. Thus, I would urge strongly that a good federal health policy must increase its provisions for training adequate numbers of black health educators and health researchers. No, my dear friends, we have not yet had "too much research."

In the area of health manpower, we must also be greatly concerned about those who represent us in the making and execution of health policies. We should monitor carefully, for example, and aid wherever possible, the work of Mrs. Minnie Gaston of Birmingham, and Dr. Frank Royal, of Richmond, Virginia, in their service as the only two blacks on the National Council on Health Planning and Development. While these two blacks just mentioned are competent, we must also be careful–very careful–that we are not trapped, as we frequently were under the "War on Poverty," by having blacks represent us who could not deal "chi-square with chi-square." In other words, our black representatives must be at least as knowledgeable and competent as the whites with whom they serve. And make no mistake about it, there is a sufficient cadre of blacks interested in, and knowledgable, and competent about health to represent us on these various boards.

A final issue related to health manpower is that blacks must make certain that we are not caught short with a second-class level of health manpower. The National Health Service Corps and the increasing use of paraprofessional health personnel are not specifically useful in improving overall the delivery of health care services to us. We must make certain that an effective national health insurance program provides the best of health care personnel as our gatekeepers to health care.

HEALTH NORMS. There are many norms which we could discuss here, one of which I have mentioned earlier–our own general responsibility to take care of ourselves. The two issues which I shall comment upon here, however, are those of the availability of abortion resources and of the minimum age eligibility for black primary beneficiaries of OASDHI.

> First, I am gravely concerned that many black women in the future will not have appropriate resources for safe abortions. Consequently, I hope that this Conference will go on record to work actively against any efforts which deny women, themselves, the opportunity of making decisions to abort. In other words, any national health insurance program should make certain that any woman who seeks an abortion will be able to have a safe one, with the costs prorated according to financial condition, as long as the woman herself wishes the abortion and it is not detrimental to her physical health. Appropriate provision should also be made for mental health services in the event that such abortions later impact negatively against her mental health, particularly during her menopausal and postmenopausal years.

Secondly, I was, in some sense, heartened to hear Joseph Califano, Secretary of HEW, at a recent meeting of the Congressional Black Caucus Legislative Workshops, refer to the fact that many black males frequently do not live long enough to draw their benefits as primary beneficiaries of OASDHI. While he, no doubt, has no idea of the origin of that observation, it was, as some of you may know, I who first proposed it in 1968, at an annual meeting of the Gerontological Society in Denver, Colorado. Since that time, however, the population group on which the observation was based has changed considerably. Other factors must now be considered in judging its merits. In truth, I had almost forgotten about it until recent Congressional actions to raise the mandatory retirement age for many Americans. I would urge modification of those proposals by urging relevant health research to determine what race specific differentials, if any, should be applied in setting retirement ages for Americans. In any case, Social Security should not be saved by Americans riding disproportionately long and hard on the backs of dead blacks. This, then, is another reason why I would urge that any effective national health insurance program include provisions for research funds to evaluate its programs, with appropriate portions of those funds going to competent black researchers.

In conclusion, I thank you for your attention, and I urge you in your deliberations today and tomorrow to consider quite seriously the importance of emphasizing preferential treatment for blacks, wherever necessary in developing meaningful policies for a national health insurance program. Please consider especially the need to remember that we should never give medicine more credit than it deserves, which means that we need policies which will improve health prevention and health education, and the expansion of health personnel who will assist us in those directons.

DR. THOMPSON: Dr. Jackson's points are well taken; she has given us some additional issues to be concerned with as we conduct this conference. Our next speaker is Congressman Corman.

James C. Corman, Democrat - California

CONG CORMAN: Thank you very much. I apologize for the limitation on my time, but there is a vote on the floor at two o'clock, and I must get back for that.

I must say that this is a comprehensive conference. I came prepared to talk about national health insurance, and find that we have also gotten into South Africa and illegal aliens. In that latter respect, we all know where I am from. I am reminded in that instance, as I am in many other instances, that this nation is plagued by its history. We have to remember that just a few years before we decided that we would no longer buy and sell each other, we sent an army out to California, seized that land from the Spanish and Indian people who had settled there for 200 years, and threw them out. So I think we have to consider where we have been when we look at where we are and what we ought to do about it. It is a terribly complex problem and involves much human misery and human suffering.

Let me talk to you just very quickly about national health insurance. I was pleased that Senator Kennedy was here because he knows so much about the whole broad range, not only of what we hope to do in national health insurance, but where we need to move to provide more manpower, more openess in manpower training, and so forth. I say parenthetically that I am proud of my state in the Bakke case. I hope to heaven they prevail before the Supreme Court, and if they do not I fear we may have to back off and find some additional remedies to end the kinds of discrimination that we have been plagued with for so long. I hope the Court is still a tool for us in that respect. We will know sooner than we think, I suppose. I hope that we do not have to rely on the Congress. They are not in a good mood these days.

I will try to address some fundamental things. First, I am going to tell you and I hope you will tell the President – that I think it absolutely essential that we move forward with national health insurance. I also think we are going to do just that in the next three or four years. I hope the President sends us down a good, comprehensive program early next year, and gives the Congress a chance to start some hearings. I have to tell you that I cannot anticipate what we will legislate next year. Our calendar is too full. We have not had enough time to digest what we have gotten so far.

I will say this about President Carter. I have been in public office for many years, but I have never before seen a politician who thought he had some moral obligation to the people who elected him, to carry out his campaign promises. He really thinks he is supposed to do that. What did he promise? He promised a national energy policy. He promised tax reform. He promised full employment. He promised national health insurance. Do you know what he is doing to us? He is sending us proposals to accomplish those things. And do you know what we are going to do? I hope to heaven we are going to work with him; the American people are entitled to it. That is why they voted for him and I suppose that is why they voted for us.

Second, I would like to address some of the nitty-gritty of national health insurance. It seems to me that we must have a public system. Now there is debate in Congress, and I understand there is debate in the administration, about whether or not there has to be a role for the private insurance companies. Well, we will figure out some role for them, but not as underwriters of national health insurance. Because to do that you have to do one of two things or both. You have to leave some services out so they have something to cover or you have to leave some people out so they have someone left to sell their product to. And they would love to skim off a little bit at the top and let us worry about the rest, as we do now to some extent. But the system must be public, and it must be compulsory. If it isn't, people aren't going to want to get into it when they are well, but they will need to be in it when they are sick. We just have to have a system that everybody pays into when they have income so that when they get sick, whether they have income or not, they have access to health care. If it's compulsory and if it's universal , we can manage that $140 billion we need tolerably well. We are doing it now through taxes, through private insurance premiums, and through out-of-pocket expenses in time of illness. It will be much easier to do it if we do it on the basis of taxes at the time we are earning money. I think the financial formula is a good one. Take half of it out of general revenues - that is about how much we take now, almost as much for Medicare as for Medicaid- and take the other half as a tax on employers and employees. It is true it will be a new tax, but immediately they will be relieved of those private insurance premiums which climb up every year.

I would also urge that we have a system that has no deductibles or co-payments. Now, as I understand the theory of deductibles and co-payments, you need some reason to keep people from going to the doctor. Well, there is a good reason for people not to go to the doctor, and that is when they are *well*. Let's figure out some way to keep more people well longer, and keep them away from the doctor that way. But don't put an economic barrier between a sick patient and a doctor, hoping that you can make it big enough to discourage people from going. We have that barrier now.

It costs almost everybody something to go to the doctor. However there is the fact that there are people who pretend to be ill when they are not, and they go to the doctor too much. It takes two to overutilize, a patient and a doctor. If the doctor is going to be paid the same amount for each patient he cares for, I think he will use his own good judgment and treat people who are ill, and give short shift to those who are overutilizing.

By way of contrast, consider the old Nixon plan. It still has some supporters around; it said that, first of all, if people are poor enough, we will help them pay their insurance premiums. Well, then you have got to monitor everybody just to see how poor they are. Then, there is the problem that in addition to paying peoples' insurance premiums, we have to figure out how much they have paid already this year for health care, because after they have paid so much we are going to start helping them. So for every American you have to monitor how much do you make, how much you have paid so far in health care, and how much do you pay of the balance. All this would cost at least $3 billion to administer. I would rather spend $3 billion training people how to be doctors and nurses, paramedicals or social workers, or providing facilities in places where there are none, and to rely on some other mechanism to prevent overutilization. Then there is the problem of how comprehensive we want all this to be. There are some, and they are very respected Senators, Long and Ribicoff, for two, who say, "Well, let's let the American people take care of most of their medical needs, but when a catastrophe hits, then we will step in."

Well, that sounds kind of good at first blush. But what is a catastrophe? I suspect that a catastrophe for some people in my district comes to them earlier than it does to me because we don't all make the same amount of money. I suspect also that if we start taking care of only catastrophic illness, that that is where most health care will be delivered. We do that now in a sense. If you think about it, under Medicaid and in some instances Medicare, we take care of the very expensive things. For most Americans, if they live to a ripe old age,about half of all the dollars spent on health insurance for them over an entire lifetime will be spent during the last six months of life in intensive care. This happens because that is when Uncle Sam says he will pay for it, and somehow or other it seems we provide the hospitals and the doctors to perform the necessary services. That is not good health care distribution, and it is why we must have very broad comprehensive coverage, including preventive care, if we are going to make any sense out of all this.

Now it will cost about the same amount either way. I don't know for sure how you work in the factor of the great free enterprise system. I believe in free enterprise. I think it's great. It is a way to provide automobiles and television sets. But I have never thought it quite fit delivering health care; I was never able to save my money for a year and decide whether to have an appendectomy or tonsillectomy, and once I decided to have it, to go get five sealed bids. It doesn't exactly work like that. But perhaps we can set up some mechanisms and make some commitments to some health care providers that, if they will keep people well, they can make some profit, and perhaps there is a chance to do that in HMO's.

I have got about another six or seven minutes and I would be glad to respond to questions, and I want to tell you in all modesty, I can answer any question you have. I want to preface that with a little story about an old, midwestern college. There was an old professor who taught theology, and his class was very popular. Every kid in school took it whether he was a theology major or not because he always asked the same final exam question, "Discuss the wanderings of St. Paul." After 30 years of this, he walked up on exam day and wrote across the board, "Criticize the Sermon on the Mount." The students were devasted; most just scribbled a line or two and walked out, except for one young man who had never been particularly good in any of his classes. He sat there and wrote for the full three hours. His buddies waited for him, and said, "How in the world were you able to answer that question so completely?" He said, "Well, after the first sentence it was easy. I started out, 'I leave it to others to criticize our Savior. As for me, I prefer to discuss the wanderings of St. Paul.'"

So I will be able to answer any questions you have.

DR. THOMPSON: Congressman Corman, thank you very much for your good words in telling us what is happening with national health insurance and for elaborating on other pertinent issues. We are very fortunate when we can get members of Congress to participate in this kind of conference; thank you again for rearranging your busy schedule to be with us.

Mr. Onek is our next presenter. You have heard a number of issues raised; we hope that, in addition to answering some questions, you will also tell us about some of the upcoming and proposed policies of the Carter administration.

Joseph Onek, White House Domestic Council Policy Staff

MR. ONEK: Thank you very much. Between Dr. Jackson and Senator Kennedy and Congressman Corman, I have a pretty tough act to follow. I will do my best at least to lay out the rudiments of the administration's viewpoint and policies. First of all, as the previous speakers have mentioned, the President is committed to sending to Congress early next year a national health insurance proposal. This proposal is still open, as Congressman Corman suggested. Of the three elements he discussed, he said it should be compulsory, it should be universal, and it should be public. I think it is probably fair to say that for the first two, there is not much argument in the administration; that is, it will be mandatory, everybody will have to belong, and I think there are different reasons for saying why that should be so.

Congressman Corman gave some of those reasons, but the most important is that in a voluntary system people who are going to be left out are the same people who are left out of the system we have now–the poor and the near poor–and I don't think we can have such a system. We must have a system where everybody belongs. Universality is the other side of the same coin. On the public-private issue there are disputes, and I think if we have time in the question and answer period, I can go over the arguments on both sides, at least as I have heard them from proponents of the different viewpoints. But the first two points, which I think are crucial, are that we will have a national health insurance program and it will be universal. I think that is clear and we certainly look forward to getting helpful input from this conference and similar groups.

Now, somebody has said, "Should we be out there marching in the streets," and Congressman Corman said he didn't discourage it; he also pointed out that this might have to be an issue in the elections. I think that is true about national health insurance, and it is true about some of the other issues I will talk about. There are often very strong constituencies that are opposed to change for economic and other reasons, and the people who would benefit from change but who may not have the same economic resources, nevertheless have to make their voices heard one way or another. The ballot box is probably the best. Letter writing to congressmen and senators is another method. But you have to make your voices heard; on all these issues I am talking about, there are many constituencies in Washington, many lobbyists on the other side.

Although national health insurance won't be introduced until next year, and as Congressman Corman said may not pass for a year or so beyond that, it does not mean that we are doing nothing in the meantime; there are a variety of steps that we have taken. I will just go over them quite briefly, just administratively. Secretary Califano, at HEW, is making a major effort to increase immunization. It is a tragedy that there are still many children in this country who are not immunized against polio, measles, and other diseases, as many as 40 to 50 percent. Our goal is just to end that problem, working with schools and other agencies to make sure that every child is immunized. There is no more cost-effective way of delivering health care than that. Somebody mentioned help for nurses because so many nurses provide primary care. There will pass, I believe next week, a bill that we have supported, to make sure that there is Medicare- Medicaid reimbursement for physician extenders. These include nurse-practitioners and others in rural clinics. The Congress, concerned about various aspects of the Medicare- Medicaid program, wants to start with the rural clinics first, where they felt the greatest need is. But of course that is a concept that can be extended if it works. So there will be better coverage under Medicare and Medicaid for physcian extenders than there has been in the past.

We have also passed a Medicare and Medicaid fraud and abuse bill. I do think it is crucial, if we are going to move to national health insurance, that we demonstrate that programs which serve poor people serve all Americans, and can be run effectively and that there aren't rip-offs. Because when there are rip-offs, you see the headlines, and sectors of the American public say, "Well, we won't have any more Medicare-Medicaid, or we won't vote for them." So I think that was an important measure. We have introduced legislation, the Childhood Health Assessment Program, which is meant to upgrade the Early Periodic Screening and Diagnosis Treatment Program (EPSDT) under Medicaid. That program to screen children has not worked well. It doesn't cover all children. We are trying to improve that. Finally, we have introduced a cost containment policy. I want to stress that our goal in cost containment is not simply to save money; it is to save money in order to spend it more effectively for health. Secretary Califano testified before the Finance Committee recently and pointed out that if they had passed our cost containment bill when we asked them to, we would already have enough money to pay for the CHAP Program twice over for this year; the savings that can be achieved are enormous and the needs are great.

That brings me to a point that several other speakers have brought up. Health means more than medical care. What we need is not just a national health insurance program, but a national health policy. As all of you know, health depends on adequate

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food and adequate housing. It depends on safe streets. It depends on safe highways. In each of those areas, we have got to decide how much should be spent to correct those problems and be willing to spend it. We shouldn't just say blindly that we will give all the money to medical care. We have got to think about other needs.

In this administration we are taking a close look at OSHA. There is a lot of feeling that workers are not being protected enough on the job, and that maybe too much effort is being devoted to minor things like how many rungs there should be on a ladder, and not enough on chemicals in plants, brown dust, white dust, and other things that are killing thousands of workers and injuring many millions of others each year. The same with air pollution and water pollution. Of course we know that there are many things that we do ourselves that are very unhealthful: drinking, smoking, the way we drive. There are no easy answers to those problems. If any of you have answers, please let us know. How do you get people to stop smoking? Most people know that they shouldn't smoke. As Mark Twain said, "It is very easy to stop. I have stopped 1,000 times." Many people try to stop; they fail. But that is something that would do a tremendous amount of good. I have heard estimates from the National Cancer Institute that we could reduce cancer in males 50 percent if we eliminated smoking. The statistics for females, who haven't been smoking for as long a time, aren't as clear, but probably are of the same order of magnitude.

All of you know the ravages of alcohol, not just directly in such things as liver disease, but in connection with traffic accidents, child abuse, and homicide, where alcohol plays a leading role. We don't have the answers, but we do know that we have to be willing to spend the resources on the federal level, the state and local levels, and in universities. And in order to do that, we have to make sure that not every dollar we spend for health goes into medical care.

In closing, I would like to say that the President promised that this would be an open administration. I hope that all of you, when you are here in Washington, get a chance to speak to various officials in the areas that you are concerned about. That means at the Occupational Safety & Health Administration, the Environmental Protection Agency, and others. I hope that you will find and I hope that you already have found that doors are open that may not have been open in the past; that you can get to see the relevant decision-makers, although that is not always the person with the fanciest title. It may be somebody down in the bureaucracy who really helps decide, for example, how much money gets allocated to which medical school. But I hope that you are beginning to find out who those people are and that they are receptive. If you find that they are not receptive, if you feel that the President's promise of openness is not being fulfilled, I hope that you will let me know and let other people know, because that is a promise that we can keep. Some promises are difficult to keep because a lot depends on what Congress does and what other people do. Our economic and other policies may depend on what happens in Saudi Arabia, but the promise of openness, of trying to discuss and meet with all kinds of people - that we can meet and that we will meet must be kept. If you have any problems on this trip in Washington, or any others, please let me know about it. Thank you.

■ *Howard Hiatt, M.D., Harvard University*

DR. HIATT: What does a speaker do when he reaches the platform and finds that the four previous speakers, starting with Dr. Jackson, have given his message, but in much better fashion that he could do himself? I will nonetheless go through it just to show you that at least one physician in this audience or on this platform is in strong agreement with everything that you have heard.

An item on one of the network news broadcasts this week described a city in Texas of medium size, that is attempting to recruit what was described as a neonatologist. A neonatologist is a fancy word for a pediatrician who looks after newborns. It is one more reflection of the specialization that has taken place in medicine. The reporter indicated that in this city, the infant mortality was twice the national average, and that community leaders are particularly anxious to recruit the specialist in order to do something about that problem. I would like to present just a few observations which indicate that, however desirable it may be for that city to succeed in recruiting that doctor, their success in meeting the underlying problem of infant mortality is going to require a great deal more.

You have heard the background for this presented already, but let me just cite a couple of examples. The British, 30 years ago, decided that national health insurance, by itself, was not going to be adequate to meet the health needs of their people, so they initiated a rather profound change in the organization of their medical care system something that is called their National Health Service.

It has many failings. It has been criticized by many Americans. It certainly is not held in high repute by the AMA. But if you ask the question as to whether every citizen of the British Isles, independent of income, independent of geography, independent of age, has access to medical care, the answer is affirmative. There is also regionalization of resources so that some considerable effort is expanded in avoiding duplication. The British last year spent something in excess of 5 percent of their gross national product on health services in contrast to the 8 1/2 percent that you heard Senator Kennedy say that we have spent, and I think it would be very difficult to make a case for the view that the general level of health in the British Isles has appreciably suffered because of this discrepancy.

Now with all of that, a study was carried out recently by the Minister of Health for Scotland, who showed that infant mortality among what is called Social Class 1, the professionals in British society, is less than half the infant mortality in Social Class 5, the unskilled workers. A number of other differences in health status can also be shown. Death rates are higher in Class 5. There is more acute illness. There is more chronic illness. There is more illness that keeps people away from work. Interestingly, there is more cigarette smoking. Over 60 percent of the males in Class 5 smoke cigarettes; fewer than 40 percent of the males in Class 1 smoke cigarettes. So Class 5 will be favored with more lung cancer, not only now, but 20 years from now when they begin to reap the benefits of cigarette smoking. There is less immunization among Class 5 children. Only one percent of the kids in Class 1 are not immunized against polio and diphtheria. More than 10 percent of kids in Class 5 are in that category. Both categories, incidentally, are far better off than in the United States.

All of this is by way of saying that even a change in the health service, and a change that is much more profound than anybody in our administration or Congress has proposed or could reasonably expect to enact, has not had an effect on equalizing health status from one class to another. Lest you think that this is peculiar to the British, experiments have been run in this country that say the same thing. Several years ago, a group of some 2,000 Navajo Indians in the Southwest, in an area called Many Farms, were looked at by a group of doctors under the auspices of the U.S. Public Health Service. It was then decided that this area would be exposed to as much in the way of medical service as was possible. Doctors, a regional health center, nurses, educators, social workers, and transportation to and from medical facilities were provided so that the whole area was covered.

After six years, infant mortality had not changed. Death rates among men and women had not changed. There was some decrease in new cases of tuberculosis. There was some decrease in a few other infections. But the general picture was approximately what it had been before. What else had not changed was the level of poverty, the abominable housing conditions under which most people live, the inadequacies in water supply, the crowding, the inadequacies in diet. Obviously, this is not an argument not to have health insurance and not to have a change in our health care system. Both of these are required. But as Dr. Jackson pointed out and as Mr. Onek has just emphasized, we must not stop there. We must institute changes in policy with realistic expectations of what they can produce. We have seen, repeatedly, changes undertaken with unrealistic expectations and with disappointment as a result. Many of the programs of the sixties, that are now heavily criticized, did far more than there was any reason to expect. But the unrealistic expectations that they would solve all problems could not possibly be fulfilled.

Now Dr. Thompson asked me to say a few words about what is going on at the Harvard School of Public Health, and I can respond first by saying, "too little." If the government works slowly, universities work much, much more slowly. But we are changing the emphasis, and we are changing the emphasis to recognize the realities that I have just described. That is to say, therapeutic medicine is not only costly, but it is inadequate to the tasks. Therefore, our programs, particularly our new programs, are putting emphasis in two areas. One is in the area of policy and management. How do we allocate resources more intelligently? How do we manage the uses of those resources more intelligently? I was moved a year ago to hear the Minister of Health in one of the East African countries, Kenya, tell me that as much as they need more doctors, more nurses and more health auxiliaries, they need even more those people who can help them allocate their resources and manage their use more intelligently. Kenya is a country in which 80 percent of the total health budget, which is very, very small, is spent to support the teaching hospital in the city of Nairobi. So we are looking at how we are using our resources. We are looking at such questions, as why, in the Medicaid budget of the State of Massachusetts, that is being threatened at the present time, the second most common cost on that budget is for tonsillectomy.

What do we achieve with tonsillectomy ? A million kids in this country were subjected to tonsillectomy in the last year for which we have good figures, and those tonsillectomies are obviously not without risk. So there is great human cost as well as economic cost. In the view of many authorities, that number of tonsillectomies may well have been 10 times, 20 times, or 30 times as many as were justified. We are attempting to look at a whole series of procedures that are being used, to see whether there is, in fact, justification, and if so, what that justification is. Coronary artery bypass graft surgery is one of the more common procedures that you read about these days. It is dramatic. It was carried out on 70,000 Americans last year. It costs something of the order of $12,000 to $15,000 per procedure. That is a billion dollars. Generally, that cost is taken, not from the individual, but from all of us, because it comes ultimately from health insurance. What are we achieving? We don't know; the evidence isn't in yet.

So we are looking at such questions as this. We are training people to ask these questions. We are training people to manage effectively organizations that are concerned with health services. We are going much more heavily into mid-career education. We are looking at those people who already have major responsibilities and who have been out of school for 10, 20, or 30 years, and who need to come back, or who could profit from coming back for the three weeks or four weeks or six weeks of intensive exposure to recent concepts and methods that help us allocate resources more effectively.

As has been implied by several people, every dollar we spend on a renal dialysis, or every dollar we spend on coronary artery bypass graft surgery, is that much less money available for immunization programs or for other aspects of our health care system. We have reached the point where we are going to have to make some pretty tough choices. We have got to really be prepared to develop the information that will help us make these choices intelligently. The other area that we are spending more and more of our effort is on disease prevention. What are the substances in our society that cause cancer, that cause heart disease, that lead to infectious diseases that have not yet been controlled? Moreover, what do we do with that information when we have it? We know, as Mr. Onek said, that something in excess of 65,000 American males will die of lung cancer this year. That is probably 65,000 preventable deaths. We know that more young girls began to smoke last year than in any year previously. We are going to have equal rights pretty soon-equal rights to lung cancer, as the number of young women who smoke becomes equal to the number of men who smoke. How do we get these people to change their behavior in their own self-interest? Well, those are just a few highlights. But I think the essential thing is that we are attempting now to work closely with our colleagues in other parts of the university, with people in the Law School, people in the Business School, and people in the School of Management, to indicate that health is really the business, not only of physicians, but of all members of our society. Finally, we are attempting to build stronger bridges to people outside the university, to try to understand their perceptions of educational needs, and what we can do to be responsive to these needs; and to people with whom we can work in an effort to see how well our students are doing in what they go into. If they are not doing well, we want to improve their performance.

Thank you very much.

PLENARY SESSION II

TOPIC II: THE FORMULATION OF PUBLIC POLICY: PROCESS OF IMPLEMENTATION

MODERATOR

Theodis Thompson, Ph.D., M.P.A.

................................PANEL................................

- **Lorin Kerr, M.D.**, Director of Occupational Health, United Mine Workers of America, Washington, D.C.
- **John Kelso**, Deputy Administrator, Health Services Administration, Public Health Service, U.S. Department of Health, Education and Welfare.
- **Ronald V. Dellums**, Democrat - California; Chairman, District of Columbia Subcommittee on Fiscal Affairs.
- **Harry Cain, II, Ph.D.**, Director, Bureau of Health Planning and Resources Development, Health Resources Administration, Public Health Service, U.S. Department of Health, Education and Welfare.

SUMMARY OF PANEL PRESENTATIONS

TOPIC II: THE FORMULATION OF PUBLIC POLICY: PROCESS OF IMPLEMENTATION

The session opened with Dr. Lorin Kerr of the United Mine Workers. Dr. Kerr's discussion of occupational health problems and the need to eradicate occupational disease emphasized the importance of viewing health from all perspectives. He pointed out the lack of attention given to occupational health prior to enactment of the Federal Coal Mine Health and Safety Act of 1969 and the Occupational Safety and Health Act of 1970. He also noted, however, that the first identification of occupational health was over 5,000 years ago by the black physician, Imhotep. According to Dr. Kerr, the major deterrent to formulation and implementation of an effective health policy in industrial medicine has been the schism existing between management and workers. But the prevention of job-related diseases would provide a major method of controlling the soaring costs of medical care, according to Kerr. He stated that ecologists and others concerned with environmental health are slowly becoming aware of what has long been known to workers-that the eight hours on the job can be the most dangerous daily threat to their health, with the greatest threat being to the black worker, who is much more likely to be employed in more hazardous occupations than are whites and other ethnic minority groups. Dr. Kerr cited the case of black coke oven workers, who have seven times more lung cancer than their white colleagues because of greater exposure to occupational carcinogens. Dr. Kerr believes that these occupational health problems can only be solved through national health service legislation. "Medicare has already taught us that national health insurance, with all the good will in the world, cannot do it."

The next presentor was John Kelso of HSA. According to Mr. Kelso, policy is formulated in federal government agencies in one of four interdependent ways. These four ways are (1) the legislative process, (2) regulations development, (3) budget review and approval, and (4) grants management. Mr. Kelso illustrated these four steps with examples from the health services programs under the jurisdiction of the Health Services Administration of the Public Health Service.

The third presentation featured a discussion by Congressman Dellums, enlarging on Dr. Kerr's statement supporting a national health service. Congressman Dellums criticized the present structure and organization for providing health and medical care services in this country. He called for a reform of the health care system that would focus on four major issues:

1) Lack of public accountability;
2) Poorly distributed and inaccessible services;
3) Unreliable quality; and
4) Excessive costs.

Congressman Dellums is the principal sponsor of the National Health Service Act, which addresses issues related to the formulation and implementation of a national health care scheme. Dellums described health education, prevention, and "health as a right" as the central themes of his proposal. The American Public Health Association has offered its support to the National Health Service Bill. Dellums also opposes the efforts of fellow members of Congress to keep health care in the market place. Emphasizing that members of Congress receive free health and medical care from Walter Reed Army and Bethesda Naval Hospitals....He pointed out that "members of the House and Senate receive all the socialized medicine they want." Dellums also commented on mental health: "The reason why black folks have a hell of a lot of hypertension is because it is tense being a 'nigger' in this society."

The final speaker, Dr. Harry Cain, focused his discussion on the current developments underway to implement the provision of Public Law 93-641, the Health Planning and Resources Development Act of 1974. Dr. Cain provided a quick overview of where the health planning program is currently, what changes are being proposed, and how these changes can be more effectively implemented. Dr. Cain stated that it is anticipated that health planning agencies will play an important role in the effort to contain the rising costs of health care. One change will be to expand the scope of the certificate of need program to include expensive equipment to be purchased for use in ambulatory settings. However, there are no mechanisms to ensure the impact of health planning agencies on such cost decisions. Dr. Cain also pointed out that the new health planning regulations have proposed standards to be adhered to in the various health service areas throughout the country. In closing, he noted that the major emphasis placed on cost containment by the Carter Administration can "hurt the access to health care." On the other hand, if rising costs are not contained, access to health care cannot be extended. The result is a "two-edged sword."

AUDIENCE QUESTIONS & ANSWERS FOR PANEL II

MR. HAINE: Leroy Haine, Howard University Hospital. Dr. Cain, you mentioned some proposed changes. What about the possibility of getting some type of regulation to require representativeness on the provider side of the governing boards, and, also, what do you feel would be the possibility of increasing the representativeness of the professional staff in the planning agencies?

DR. CAIN: It is quite within the purview of HEW's current authority to watch the issue of the professional staffs quite closely, and if we do find, as these early statistics show, that the professional staffs aren't adequately representative, we can take some action ourselves. That isn't so on the side of how representative are the providers. That would take specific action by the Hill. The Act requires that the consumers on these HSAs are representative of the community, but it doesn't say anything about the providers.

DR. THOMPSON: Is there anyone who has questions for Congressman Dellums? He has to leave.

MR. LOADHOLT: Congressman Dellums, you spoke about accountability, concerning the consumer and the community. I would like to know just how you can have accountability in the medical profession unless the government puts some pressure on the states to enact laws to deal with Community Boards, taking the word "advisory" out of the title. Until that word is dismissed from the Community Boards, we will never have accountability in our communities, and the millions of dollars that are wasted will be wasted forever.

CONG. DELLUMS: I appreciate the question. I think you probably answered the question in asking it. That is, consumers have a right to be involved and should be involved in the development, establishment, and maintenance of any delivery system for health. Let me try to answer it specifically within the framework of our own legislation. The way we try to handle accountability is to establish a locally elected board that sends representatives to a district, a regional, and a national board. But the mechanism is not a top-down process; it is a bottom-up process where you begin by electing people, so our boards are not advisory. These boards are duly elected boards with all of the *authority* of a board of directors that is spelled out in very specific terms in our piece of legislation. So I have to answer you within the framework of our bill. We recognize it; we see the need for consumers to be involved not only in the planning and the advisory functions but also in the administration. Consumers have a right, it seems to me, to be involved in that process. That is why we established in very specific terms the role of consumers in a duly elected process so that it is not advisory.

I would suggest to you that any other mechanism is never going to deal with that problem. To get laws passed to make the states establish accountability, you would have to go back and unravel literally myriad pieces of legislation. If you are going to deal with it, I would suggest that you deal with it cleanly one time and establish a mechanism from the bottom up that allows you to have people significantly involved beyond an advisory capacity. That is articulated very specifically in our bill.

MR. WHITE: Congressman Dellums, my name is Joe White. I am from the University of California and I am a professor of psychology and psychiatry. I wonder if you would comment on any possible relationship between the piece of legislation you have introduced and the Kennedy/Corman bill. I would also like to hear something from you with regard to what you see as the possible timetable in terms of the phasing in of the type of legislation that you are proposing.

CONG. DELLUMS: Let me deal with the latter part first. In our bill we perceive a four-year phase-out, phase-in process, so it wouldn't happen overnight. The ingredients for such a health service already exist in the hundreds of community health centers across the country, in prepaid health plans, in HMOs that many of us have joined, in public hospitals and neighborhood clinics that many of us use. The Health Service Act prescribes a four-year transition process during which health boards can be chosen, health workers hired, and the existing network of health facilities expanded and brought together into a coordinated comprehensive mechanism. We suggest four years because we don't think you have to invent the wheel all over again. There are neighborhood clinics out there; there are HMOs out there; there are public hospitals and facilities out there. What we need to do is to bring them together, expand them, develop a coordinated network, elect the boards, hire the personnel, and we think in four years we can begin this process.

With respect to the Kennedy/Corman: first, the last study we saw, approximately 25 percent of the American people right now, without any further discussion or debate, are in support of a national health service. Approximately 35 percent of the American people at this point want a national health insurance approach. The combination of that is about 60 percent of the American people who already want some very drastic move on the part of the federal government toward a universal comprehensive approach. An organization helping us, developed 12 key questions to ask that allows you to compare the two approaches. I will ask the questions, and I will show you the difference between their bill and ours:

1) Is the major support for the plan consumer rather than provider? Kennedy/Corman, yes; Dellums, yes.

2) Is the plan universal? Yes, to both.

3) Does the bill provide comprehensive rather than limited benefits? Yes, to both.

4) Does the plan encourage preventive care and not just hospital care? Kennedy/Corman, yes; Dellums, yes.

5) Does the plan eliminate co-insurance and deductibles which discourage people from getting care? Yes, on both.

6) Is the financing progressive so that the cost is not the burden of low and middle income persons? Dellums, unequivocally yes; Kennedy/Corman, somewhat.

7) Is profit-making excluded from the financial administration? Yes, in both.

8) Is profit-making excluded from the delivery of health care? Dellums, yes; Kennedy/Corman, no.

9) Is the national administration of the plan in federal rather than in private profit-making hands? Yes, in both.

10) Is the control of the system on the local level in the hands of the consumers where possible? Kennedy/Corman, somewhat; Dellums, yes.

11) Does the plan have effective cost and quality controls? Kennedy/Corman, somewhat; ours, yes.

12) Will the plan improve the distribution of doctors, develop new resources, coordinate services, and make the system more accountable? We feel the answer to that is, yes, as we have tried to construct our bill; as objectively as possible in evaluating the Kennedy/Corman bill, our answer to that question is, somewhat.

At some levels we are going down the same road in the same direction, but in large measure Kennedy/Corman is still talking about a transfer of finance mechanism. In our bill we are really talking about a radical altering of our entire delivery system of health, a different way of seeing it. While there are areas of compatibility, there are areas where we have gone beyond their particular piece of legislation. At this particular point it is not our tactical or strategic position to engage in a war with the organization; both of us are trying to stimulate a national debate so that the American people can look at the total range of alternatives.

MS. HICKMAN: My name is Christine Hickman, I am a lawyer with the Center for Law and Social Policy here in Washington. I just wanted to comment on a theme you raised in your remarks about the location of hospital services in areas away from the black population. It has been our experience in the last 10 years that many hospitals that serve black populations have moved from the inner city to white suburbs. They have done this with the blessing, financial assistance, and civil rights clearance of HEW. Unfortunately, that situation is continuing. The most dramatic example of this, we think, is in Wilmington, Delaware where a major hospital, 1,100 of the 1,400 beds in the county, is moving the majority of its facilities from the inner city where 90 percent of the black population lives to a predominately white suburb. HEW has reviewed the situation and has announced in court last week that they are going to give, with some modifications, civil rights clearance to this plan. This will leave the City of Wilmington with no pediatric beds and no obstetric beds; it is a move that could not take place were it not for the Medicare and Medicaid assistance and civil rights clearance given it by the federal government. We would hope you, Congressman Dellums, and the Congressional Black Caucus would find this kind of civil rights clearance as unacceptable, repudiation of civil rights responsibilities of the government, and could bring pressure to bear in trying to turn this HEW action around. In my mind there is no difference in locating a hospital where black people can't get to it than in putting up a sign saying blacks may not come in. This is the first time, to our knowledge, that HEW has looked closely at the relocation problem, therefore, it is doubly important that they not be allowed to let this hospital move the majority of its facilities out to the suburbs.

CONG. DELLUMS: I think you have made the point. I read your very articulate statement in a letter, so I assume that you are guaranteeing that I got the message.

MS. HICKMAN: That is exactly what I am doing.

CONG. DELLUMS: To answer you, yes, I got the message. I will communicate with my colleagues and I am sure we will communicate with HEW.

I think the case makes an awful lot of sense and agree that I can personally be involved in trying to help turn it around. I commit myself to do that, and I will also communicate your very articulate letter to the entire Congressional Black Caucus.

DR. THOMPSON: I am going to allow one more question. Mr. Kelso has to be downtown in just a few minutes, so this will be the last question.

MS. WILLIAMS: Mr. Kelso, I am Jai Williams, Los Angeles, California. As you have pointed out, poor distribution and unreliable services prevail in our communities; I am wondering if you could give some guidance as to developmental monies that you might be aware of for group practices (not piggyback to large medical centers) who probably will meet the certificate of need guidelines, but not those within the existing communities, particularly in urban situations such as Los Angeles where there are poor public transportation lines?

MR. KELSO: One of the obvious places I think, if you are talking about group practice, is the HMO, the Health Maintenance Organization, which is in effect a prepaid legislation that the Public Health Service has. Within our agency I am not aware of anything that deals particularly with establishing group practices. We have authorities where we can place people in underserved areas either through the National Health Service Corps, or in Community Health Centers, or combinations thereof. But it really doesn't deal specifically with establishing group practices other than the HMO program.

MS. WILLIAMS: I am talking more specifically about development funds, and I am concerned about the lack of development monies, in that certificate of need planning guidelines are sending more and more people to out-patient and emergency room departments of large medical centers who will probably circumvent certificate of need laws by establishing ambulatory surgical centers and primary care centers that people within largely black communities have a hard time traveling to. But those hospitals will stay in existence, and the providers within the community who would like to establish group practices have no capital funds to do so.

DR. KERR: A possible suggestion as to where you might get some help on that would be to contact the Group Health Association of America; this is made up entirely of predominantly consumer-sponsored group practice programs across the country. They have got quite a large membership now. This very point that you are raising is one that we have had to struggle with for a long, long time. The answers are now beginning to come forward. I think you should get in touch with them—they are here in town, the Group Health Association of America. They are located down on Massachusetts Avenue between 17th and 18th.

MS. WILLIAMS: I appreciate that suggestion, Dr. Kerr. I am a member of the Group Health Association of America, and they also don't have any development monies.

DR. KERR: No, they don't have development monies, but I thought that maybe they could tell you where you could get in touch with it and how you could pull on it.

MS. WILLIAMS: They offered the HUD, FHA Program, and I personally worked with that program for two years with no help. Maybe Dr. Cain can address this because one of the guidelines of HSA says they are willing to help support the development of group practices within communities. My question is, what action plan has actually been formulated to help in the establishment of group practices within existing communities?

DR. CAIN: I can think of three things: (1) the way the Planning Act came out; under the subsequent certificate of need regulations, it is possible we have covered this inadequately. Hence, we are just about to come out with a change in the existing certificate of need regulations to attempt to assure that that won't happen. (2) As I said, we are proposing to ask the Congress to extend the scope of certificate of need programs to include ambulatory settings as well. (3) Secretary Califano has taken a very strong stand in support of HMOs, and he is developing a program proposal in that area, but I can't tell you just what it is because I haven't spent that much time on it.

DR. THOMPSON: We would like to thank the panelists for their presentations. We are on a time schedule that we want to keep. We will be back at 4:30 for the Black Health Administrator session. To each of the panel members, thank you very much.

PLENARY SESSION II

TEXT OF PANEL PRESENTATIONS

THE FORMULATION OF PUBLIC POLICY: PROCESS OF IMPLEMENTATION

DR. THOMPSON: We would like to begin the second panel topic for this afternoon. During the first half of the afternoon we talked about the state of health policy to get some viewpoints and ideas. Now we want to talk about the formulation of public policy and the process of policy implementation. When I look at the panelists I know we are again going to get some information about the formulation of health policy. We will use the same procedure as before. The panelists have been given about 10 to 12 minutes to give their viewpoints . They have been charged to speak on specific issues related to their own area of expertise.

Our first panelist, Dr. Lorin Kerr, has had a long history in the field of public health. He is a past President of the American Public Health Association. He is currently Director of Occupational Health for the United Mine Workers of America. Dr. Lorin Kerr.

■ *Lorin Kerr, M.D., United Mine Workers of America*

DR. KERR: Thank you very much. For health professionals, occupational health, in the vernacular of economists, is a growth industry with unlimited potential. The demand for service is new and gaining a momentum unprecedented since the first identification of occupational health 5, 000 years ago by the black physician, Imhotep. This development is due almost exclusively to the enactment of the Federal Coal Mine Health and Safety Act of 1969 and the Occupational Safety Act of 1970. In the coal mine law Congress for the first time mandated that an occupational disease occurring in a major industry must be eradicated. OSHA stimulates the prevention and control of job-related illnesses and injuries occurring in the remaining 4.7 million work sites located throughout the nation.

These two laws clearly indicate that the health of the workers on the job and the effect of the job on their total health and well-being is a national health problem. With few exceptions this problem has been of scant concern to any except the workers themselves. They have regarded the occupational injuries and illnesses to which they have been subjected as necessary evils which, if they were lucky, might be avoided. This

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attitude accurately reflects the pervasive effect of the isolation of industrial medicine from the mainstream of public health and medicine. This began in the United States about the time of the Civil War. Management, with the advent of the industrial revolution, assumed control and operation of the means of production. With this responsibility came the need to assure maximum productivity of both labor and machinery. It soon became obvious that sustained effective labor production demanded reduction of absenteeism and maintenance of the workers' well-being. For economic reasons, management in most instances limited its concern for the health of the worker to the job setting. This cessation of interest in the workers' health once they walk out of the company gate led to a serious fragmentation of the workers' health needs.

Management's assumption of its isolating prerogative has sorely affected worker's compensation legislation as well as jointly negotiated labor-management medical care programs. It has also been responsible for the schism between industrial physicians and other practitioners and the extreme shortage of occupational health personnel.

Equally important has been the deadening impact of management's prerogative on attempts to incorporate occupational health in public health programs. While many industrial physicians have indicated an understanding of public health, management is disinclined to relinquish its prerogatives to any outside agency. Public health programs have constantly suffered from a lack of authority to set or enforce compliance with standards.

On occasion management has sought public health budget cuts because public health research revealed hazards that posed an economic threat. For example, the world-renowned Dr. Harper relates that while he was a commissioned officer in the U.S. Public Health Service, his epidemiologic studies on occupational cancer were forcefully and abruptly brought to a halt in 1952 by order of the Surgeon General. This followed a protest to the USPHS by the medical advisor to the chromate-producing industry on behalf of this clients.

It is estimated that currently, services for industry or employer groups are now being provided by 10,000 physicians, of whom about 2,000 are employed full-time. Of the latter group over one-fourth never see a patient. Nearly all of these physicians are located in the 11,500 establishments with more than 500 workers. These comprise less than one percent of the nation's 4.7 million work sites and employ about 25 percent of the nation's 93 million civilian workers. Almost without exception there is no organized preventive health program for the rest of the workers. Rather than a maldistribution of qualified occupational health physicians there is in reality a marked shortage.

Today, the enormity of work-related death and disability is becoming apparent. It has been maintained far too long that 2 million workers are injured on the job each year. Of those injured 14,000 are killed immediately or die later. A recent study indicated that a more accurate national accounting will probably reveal 20 to 25 million job-related injuries and about 25,000 deaths. These are truly shocking figures. Alarming as these figures are, there is no accurate national accounting of any job-related illness except possibly black lung. The Social Security Administration has approved payment of federal black lung benefits to somewhat more than 365,000 victims of the disease at a cumulative cost by 1976 of slightly more than $4 billion. It is conservatively estimated that the deaths of more than 4,000 miners each year can be safely attributed to black lung. About 15 percent of the working miners have x-ray evidence of some degree of coal workers' pneumoconiosis. It is likely that as information concerning specific exposures in other industries becomes available, comparable statistics will be tabulated.

Black lung, like all occupational diseases, is man-made. I think this is a terribly important point. All of the occupational diseases are man-made diseases and preventable. For instance, in the coal mining industry the preventive technology has been available for decades but never applied until the Federal Coal Mine Act mandated the disease be eliminated, and it was put in with a minor increase in the cost of production. Most of the equipment was already in place. It just was not big enough.

Five years ago it was estimated that occupational diseases caused 100,000 deaths each year. This is more than seven times greater than the estimated number of deaths caused by job-related accidents. Today, there is growing evidence to indicate that the 1972 estimate of occupational disease deaths was far too conservative. This is truly a nationwide pandemic, the prevention of which will eliminate more death and disability than has occurred with the virtual elimination of the communicable diseases. The prevention of job-related diseases also provides a major method of controlling the soaring costs of medical care. There is just now a dawning realization that pollution of the workplace is responsible for the degradation and exploitation of workers. In addition, many of the same pollutants also have a deleterious impact on the surrounding community, causing non-worker death and disability. The ecologists and others are slowly becoming aware of what has long been known to workers — that the eight hours on the job can be the most dangerous daily threat to their health. And too frequently the black worker's job is even worse. For example, black coke oven workers have seven times more lung cancer than their white colleagues. The reason is simple; the black exposure to occupational carcinogens is greater. The reason is old; the black worker too often has the dirtiest job with the worst exposure in many industries. To make matters even worse black persons are twice as likely as others to be totally disabled.

The frightening toll of dead and disabled workers can and must be halted. An important step will be the convening of the long-overdue White House Conference on Occupational Health. Such a well-publicized pronouncement would declare to the nation that the Carter Administration is committed to three major actions: elimination of job-related death and disability, initiation of a major preventive health campaign, and effective containment of medical care costs. The disability benefits provided by worker's compensation must also be revised. Today there are fifty different programs, one for each state, and none of them provided adequate help. They totally immobilize the workers because the benefits are not interchangeable between the states. The laws are a legal jungle. The only solution is a national workers compensation law.

The success of a program designed to prevent occupational diseases requires adequate monitoring and surveillance of the nation's work sites. This should be the responsibility of the local and state health departments. A major guarantee that this will really occur is the requirement for consumer-dominated governing boards of all health departments, rather than the current provider-oriented arrangement. Currently, less than 10 percent of the working population is served by strong state or local occupational health programs. State and local health agencies, in general, lack the resources and competencies needed to cope with these problems in an effective manner. Contrary to those who would leave the responsibility for administering health care programs in welfare departments, I advocate this should be placed in the hands of those already trained and knowledgeable in health, the local and state health departments. There is just about time enough to provide refresher courses in medical care administration for health department personnel. It will be catastrophic to discover, when a national health care law is enacted, that the essential local and state health professionals are non-existent. Planning and training must be initiated in the immediate future.

For more than 35 years I have actively supported and endorsed national health insurance and more recently national health security. I am now convinced that national health service is the only legislation that will control quality of care, adequately contain escalating costs, and assure the prevention, diagnosis, treatment, and rehabilitation of occupational illnesses and injuries. All health personnel will be salaried. The keystone will be the promotion of health and prevention of disease, and the program will be consumer-oriented rather than provider-dominated. With the enactment of national health service it will be possible to limit medical care costs to eight percent of the GNP, rather than the current 8.6 percent or the 12 to 15 percent we can look forward to if something is not done quickly.

With the enactment of other national health insurance legislation currently before Congress, costs will continue to rise to 12 and 15 percent of GNP. The nation will then demand implementation of effective controls. A national health service is the only logical and rational way to solve the country's health problems. Medicare has already taught us that national health insurance, with all the good will in the world, cannot do it.

DR. THOMPSON: Thank you very much, Dr. Kerr. I know that Congressman Dellums must appreciate your support for his national health service proposal. Our next panelist, Mr. John Kelso, is Deputy Administrator of the Health Services Administration, Public Health Service, HEW. We are very pleased to have Mr. Kelso here with us to talk about the formulation of public policy and give us some ideas of what the Forward Plan for Health looks like within the Health Services Administration. Mr. Kelso.

■ *John Kelso, Health Services Administration/DHEW*

MR. KELSO: I am pleased to be on this panel. Dr. George Lythcott, Administrator of HSA, wanted to be here but is in Alaska for meetings with Alaska Native leaders.

Before getting a description as to how we approach the matter of implementing health care policy within the Health Services Administration, let me take a few moments to outline what the Health Services Administration is, as well as the kinds of issues it confronts. After doing so, I then want to briefly describe each of four approaches which we routinely follow in deciding how the program is to do its job. HSA is one of the six agencies constituting the U.S. Public Health Service. The 1977 budget was 1.5 billion dollars. Our programs include the Indian Health Service, Community Health Centers, Migrant Health, Maternal and Child Health, the National Health Service Corps, Family Planning, Sickle Cell Disease, Hypertension and a number of other categorical programs. These are provided as either direct health care services or as project and formula grants to states to support these services. In addition, the Health Services Administration operates the Public Health Service hospitals and clinics and administers programs to establish and improve Emergency Medical Services Systems. The Community Health Center program, one that is getting an increasing amount of attention, is authorized by Section 330 of the Public Health Service Act and supports comprehensive health services projects for ambulatory patients in medically underserved areas. These programs alone will serve approximately 1.5 million people in 1978 (83 percent of whom are black) and will have project grant support from HSA totaling $247 million.

With this general description in mind, let me say that the direction taken on all of these programs is one which focuses on the need to improve the health of the American people. We know, from declining mortality rates and increasing longevity, that for the most part, the health status of the nation is improving. However, we recognize, as I am certain you do, that there remain large segments of the public who still do not share in these gains. We know for example, that the people we provide services to at Community Health Centers are young (62% are between the ages of 1 and 44); minority (78% black); and poor (58% of the users of these centers have incomes less than $6,000 and have no employed family member).

Our program needs are clear. Now how is policy developed and implemented?

For the most part, it is handled in any one of four ways, and all are interdependent. They are:

- The legislative process;
- Regulations development;
- Budget review and approval; and
- Grants management.

The first is through new legislation. For example, the Community Health Center program, P.L. 94-63, was enacted in July 1975. It repealed a previous section relating to health centers, and created a new section to cover the planning, development and operation of the CHCs. The law mandated a minimum package of primary health services and provided for the use of grant funds to support an array of supplemental health services that would be specific to meet the health care needs of the communities where community health centers would be located. This legislation then was vital to making important organizational and benefit type changes. Prior to the new law we had a combination of neighborhood health centers, family health centers and community health networks. While they had all been transferred to the PHS, fundamental policy differences needed to be accommodated. For example, we could now get funds to the areas in need, by clearly defining what was meant by the term "medically underserved population." With this, the Secretary was then authorized to make grants to public and non-profit groups for planning and developing community health care services. In addition, money could be made available for working on new methods of health services delivery and improving the access to comprehensive health services, particularly in areas with a high concentration of urban or rural poor. As a result of that important piece of legislation, departmental policy could more effectively reach the underserved population. In a very concrete way the program will in 1977 support 163 Community Health Centers and 258 Rural Health Initiative projects, all of which are providing a range of preventive, curative and rehabilitative ambulatory services, and arrangements for inpatient services, to over 3 million people. In 1978, support will continue for the ongoing projects, and new ones will be funded.

Legislation of course, is the best known approach to policy implementation at the national level. The other avenues are less clear and in some respects more complex. The regulations process is one of these avenues. Once new legislation is enacted, it is followed by implementing regulations. Using the instance of the Community Health Centers, in reading through the Public Health Service Act you will see that it is replete with authorities delegated to the Secretary. For example, it says that the amounts of grants "shall be determined by the Secretary," and, "overall plans and budgets shall be developed in accordance with regulations of the Secretary." The process we follow is rather complex. However, we're working on ways to simplify it. Following passage of legislation, or following a decision to issue regulations for some reason other than the passage of legislation, the agency typically takes a number of steps.

- First, a plan is drawn up which identifies the regulatory issues to be covered and establishes a timetable for the actual issuance of the regulations.
- Next, the administering agency – our Bureau of Community Health Services in the case of Community Health Center regulations – begins to consult with various individuals and groups inside and outside the agency, to secure suggestions for the content of the regulations.
- Then the agency, working with the Department's legal staff, produces a draft of the regulations.
- The draft is circulated for review and approval within the Department – and under certain circumstances is circulated outside the government.
- Then a Notice of Proposed Rulemaking is published in the Federal Register, specifying a "comment period" during which the public is encouraged to react to the proposed regulations.
- All comments are reviewed and suggested changes either accepted or rejected.
- Lastly, the final regulations are drafted, reviewed, and approved and published in the Federal Register. The final regulations are usually effective upon publication.

A third and certainly less well known system to getting the job done (at least prior to the Administration's advocacy of zero based budgeting, or ZBB) is the budget itself. It should come as no surprise to anyone in this room that the process is highly structured and consumes considerable effort throughout the agency and the Department. HSA, and all agencies in fact, must develop sets of so-called "decision packages" for all program activities. From each one, the agency then identifies program ranking, that is, the Community Health Center program would receive a ranking in a priority order. Each priority is given a further review as the budget moves through the system and eventually to the Office of Management and Budget. Depending on overall government priorities the program will either expand, remain the same, or receive a reduction in funding.

Finally, let me say a word about some of the administrative procedures which we follow in day to day program management. Having the enabling legislation, a set of regulations and an approved budget is not enough. We have found that programs need to be carefully monitored so we know whether or not health care centers are doing the job effectively and efficiently. Accordingly, we have developed a set of program indicators that tell us how well the centers are functioning. Here we use our regional offices to a very large extent. As you probably know, there are 10 regional offices located throughout the country which assist us in managing the HSA programs, and in fact have a very significant role in the day to day decision making. The program indicators are objective, uniform standards used to monitor the areas of efficiency and penetration. These indicators have been identified as one of the funding criteria which must be used by the regional offices in the grant evaluation process.

All of us face a massive problem in carrying out these many programs. The legislation is complex and comprehensive. Some aspects of policy are being shaped daily throughout the system and at all levels within that system. In many ways, we provide opportunity for input into that system that is unique – because our programs are uniquely community oriented. We learned many years ago of the importance of carrying out programs with a high level of consumer awareness and participation in the decision making process. We insist for example, that there be very specific consumer oriented policies adhered to. The policies to be developed and followed are policies that in the main need to be oriented to the community health care provide

From this kind of informed participation comes the interest in getting involved in other ways. For example, as I said earlier nearly every program we manage requires that regulations be developed. This means that every opportunity to proposed rule-making announcements affecting HSA programs should be taken advantage of by interested individuals and groups. It is here that the legal instruments are developed which direct the activities of health care providers. What services are rendered, and how they are delivered and financed, are usually defined in regulations.

In the days ahead, we see a mix of strategies and initiatives. How much is done and what is done will depend to a large extent on the level of community interest. The opportunity is there. Thank you.

DR. THOMPSON: Thank you very much, Mr. Kelso. Our next speaker is Congressman Ronald Dellums of California. Congressman Dellums, as I mentioned earlier, has been involved for about five years with health care issues in the Congress. He has been actively involved in the development of the national health service proposal now before the House of Respresentatives.

Ronald V. Dellums, Democrat - California

CONGRESSMAN DELLUMS: Thank you to our distinguished Chairperson, colleagues, and brothers and sisters. I have prepared some remarks for you, and I would like to begin by taking a very brief look at our present delivery system of health. Quality health care in America should be a right of all the people, but the tragic reality is that at this given moment that is not the case. Many Americans have no access to health care. Many more must travel long distances and wait long hours in over-crowded and understaffed facilities. Medical costs are out of control, increasing more than twice as fast as any other services or goods that we purchase.

Last year public and private expenditures for health care services in this country were approximately $140 billion. Health is a big business in America. That is approximately $2,600 for each family of four in America. Many people in this country do not fully appreciate the magnitude of health costs because many of these costs are hidden.

Conveniently located community clinics and hospitals are closed or forced to the brink of bankruptcy as giant hospital complexes swallow them up. In urban areas hospitals and clinics are not located where people need services. In Washington, D.C., for example, a most favorable ratio of health providers to health consumers exists. But if you go into Southeast Washington, if you go into Anacostia, the ratio of health providers to health consumers is below the national average. One would assume, with any reasonable application of intelligence, that the people who are most impoverished, the people who are most affected by unemployment, the people who feel the pain of oppression most intensely in our society, would for very obvious reasons have more health needs. But these are the people who have the fewest providers of health services and a gross lack of facilities in their communities. The specialties of doctors bear no relationship to the needs in the population. Those who are supposed to be served by the health care system have little, if anything, to say about what services will be provided. Finally, we face a growing epidemic of what is euphemistically referred to as "modern diseases"; heart disease, stroke, hypertension, and cancer. Our medical system seems grossly incapable of addressing these problems.

With respect to public policy, we are now engaged in a debate. There have been a number of proposals advanced. The primary focus of reform of the health care delivery system in this country to date has been on limiting the financial cost to the individual through various insurance proposals, and maybe sometime in the not-too-distant future, some kind of cost containment proposal. This avoids going to the heart of the mattter and merely tries to shift the costs without changing the present system in its basics. These proposals shift the financing of health care from a primarily private structure to a primarily public one by making the federal government the insurance company for a health delivery system that in effect remains private. The forces determining the costs are left totally untouched. Despite growing support and involvement of the federal and state governments in the health care system, we still have not managed to provide a comprehensive approach to health care in this country. The health delivery system in America is fragmented and increasingly unresponsive to the needs of the people it is intended to serve. Inside the health community there is a growing feeling that continuing to place so much emphasis on financing may in fact have a negative effect, for it only means pumping more money into what is already an inadequate and unresponsive system. Four major problem areas that are more critical to basic reform are:

1) Lack of public accountability;

2) Poorly distributed and inaccessible services;

3) Unreliable quality; and

4) Excessive costs.

Let me move to some rather specific problems with respect to legislation that has been proposed.

1) The proposals for the most part tend to focus on the means of financing rather than the quality of the system itself, and as such only pump money into an inadequate system.

2) There seems to be a perception of the need for improved health care, but few bills acknowledge health care as a basic right of human beings in this country. There is an absolute difference between recognizing the universal need for such access to health care and actually providing that access.

3) There appears to be an acceptance without question that the price mechanism is the only efficient means for allocating health services. The bills rely on privately provided services and upon some rather vague cost-plus mechanism,

4) Consumers are excluded from any input into the health system except in some illusory advisory capacity.

5) Enormous attention seems to be devoted to clerical and bookkeeping chores, rather than using scarce resources for the actual delivery of service.

6) Eligibility in none of the proposals is by any means universal. There are limits because of nationality, income, working status, *et cetera*. The net result is that lower income and minority group members face the possibility of not receiving full coverage.

7) Benefits usually are controlled, particularly in specialty areas. There seems to be little recognition of the need for preventive services.

8) Financing devices rely on regressive payroll deductions which fall hardest on low-income persons.

9) Even the bill most widely supported by the majority of labor does not provide any protection for the worker in the working place. Nowhere is occupational health considered or even mentioned in any single piece of legislation advanced, even the one most widely supported, at this moment, by labor. I believe my distinguished colleague, Dr. Kerr, has already pointed this out.

My overall conclusion is that of all these insurance proposals to provide full coverage, none of them deal with the many defects that prevent the delivery of health services to people who desperately need them. One thing links all these proposals; they are versions of national health insurance. Now, if you are wedded to the concept or the principle of insurance and insurance premiums as a framework for the delivery of health services, then obviously the Health Security Act is the best approach. But as I tried to point out, that bill has its shortcomings.

Several years ago I happened to pick up an article written by a group of young health providers out of Chicago calling themselves the Medical Committee for Human Rights. They established what I considered extraordinary principles upon which any delivery system of health ought to be designed – that health should be a right and not a privilege, that it should be comprehensive, that it should be universal, that it should be financed by a progressive tax, and that it should remove all profiteering from medicine. The notion of profiteering in health is in some way ludicrous. I became very excited about that. I felt someone black needed to enter into the national debate on the issue of health, and I decided that I wanted to do it. I wanted to get in front of a piece of legislation that embodied these principles. I am not an expert in health, so I cannot compete with the many people in this room who are experts in health. I am simply an advocate for an idea whose time, I believe, has come. Many believe that our idea is 10 years ahead of its time. I believe that the tragedy is that the politics of America as articulated by our political leaders is 10 years behind the time, so I think the situation is just in reverse. And because I believe in being politically consistent, I embarked upon a proposal that at this particular moment in our political evolution is considered quite controversial. We introduced the bill a few months ago after about four or five years worth of work with many people helping to write it. This bill, H.R. 6894, would create a publicly controlled and operated delivery system of health, employing health workers directly to serve the public. The Health Service established by this Act would provide comprehensive health care of the highest quality as a basic human right available to every person without charge, irrespective of race, creed, color, sex, income, age, language, or place of residence. It would emphasize the maintenance and enhancement of health as well as the treatment of disease, by providing preventive occupational environmental health services. It would be controlled locally, regionally, and nationally by the people it serves and by the people who work with it. It would eliminate the unnecessary waste and cost inflation resulting from the current privately controlled fee-for-service medical care in this country.

This legislation, as I stated earlier, starts with the basic principle that quality health care is the right of all the people and not the privilege of a few. Therefore, the health care received by an individual should not be determined by income. Health care is not a commodity that should be purchased in the marketplace the way we purchase a can of Right Guard. I think that one can have an uneven distribution of Mercedes-Benzes, color televisions, and diamond rings, but I think there is something tragically ludicrous about a nation that unevenly distributes health care to citizens in what is ostensibly a democratic society. I think that it can no longer be tolerated politically, morally, ethically, or economically. We have to address the serious question of radically altering the nature of our delivery system of health. We spent $140 billion in 1976, approximately 98 percent of which really went to serve approximately nine percent of the population. As I understand it, approximately nine percent of the total population is sick at any given moment – nine percent! If 98 percent of the $140 billion that we spent went to help the sick, only one percent went for health education and the prevention of illness, so in effect our entire delivery system of health serves nine percent of our population. The other 91 percent who on any given day tend to be healthy receive virtually no service because there is very little education, very little preventive service going on. Some doctors have told me that they don't get paid to prevent disease. They get paid when somebody is sick. So that is the mechanism that we have evolved.

Let me, in the remaining moments that I have, go to the specific issue of the formulation of public policy. It is interesting that serious national policies rarely get implemented in the Congress in even-numbered years. If you think about that for a moment, even-numbered years are when members of Congress trot home to get elected. The name of the game is to avoid controversy at all costs during election years. Try to name a major piece of legislation that was passed in an even numbered year. I would be shocked and surprised, brothers and sisters, if the United States Congress dealt with the issue of health delivery in this country in 1978. We didn't do it in '77, so our only hope is either '79, '81, '83 or maybe '85, not '78. I would be shocked and surprised pleasantly if we did. My opinion is that if we do anything in the next 18 months, it may be to pass some cost containment legislation, because it is quite sexy to say we have done something to put a lid on hospital costs. We may also manage to do something to put a lid on medical fees. But I think it is very important to understand one point; there is a danger in lobbying for health care reform just for sake of reform, just to get the ball rolling. This notion implies, "Well a piece of a loaf is better than no loaf, so let's get the ball rolling and maybe once we get started, we will eventually get where we want to go".

Once you allow a fragmented piece of health legislation to get passed, it will be palmed off for the next 10 years as a major reform on the part of the United States Government. But that "reform" will represent only a minor shift in the pattern of health delivery, and it will have been enacted under a propaganda barrage which will picture even small changes as dangerous first steps toward "socialism" in medicine. Then the oppressed will continue to be oppressed for another ten years.

I would like for you to consider with me for a moment that the United States Congress, members of the House and members of the Senate, receive all the socialized medicine they want when they need the services of the House physician. It is interesting when you start to talk about challenging the fee for service system, they jump up and say you are destroying the private enterprise system. But when members of the House and Senate get sick, where do they go? They go to Walter Reed and Bethesda Hospital where the doctors are on salary. Yes, where the doctors are on salary. I think it is a fundamental contradiction. If creeping socialism is good for 435 members of Congress and 100 Senators, it is damn well good for 215 million American people.

We should accept the reality that better health care alone can never solve the pressing problems, the day-to-day problems and needs of millions of oppressed people in our country. Just as badly as we need a delivery system of health that not only has the function of dealing with both curative and preventive medicine, we need an end toracism; we need an end to sexism; we need a real commitment to economic equity and economic justice; we need the creation of meaningful employment; we need the promise of a safe environment in which to live; and we need a commitment to the type of housing and education that should be afforded to all the people in this country. A health delivery system is not going to solve all these problems. But the beauty of addressing the problems of health is that it forces the country to come to grips with the full range of issues impacting on human lives. The reason black people have a high rate of hypertension is that it tense being black in this society. So we not only have to develop a delivery system of health to deal with that, we also have to eradicate those factors that create my tension. These objectives are not dreams. They can be realized and they can be realized now. But only after we achieve a massive reorganization of our priorities in this country, to place a greater premium on dealing with human misery and the human condition than building neutron bombs, MX Missiles, Trident submarines, and other such monuments to military madness while we continue to be 19th in the world in our ability to sustain human life. As long as it is politically possible to isolate black health care reform from the health needs of third world people, senior citizens, children, and the poor, then the chance for bringing about change is obviously limited, because the game has always been to play one group off against another.

The inadequate system of health care delivery effects all human beings in America. It effects black human beings, brown human beings, red human beings, yellow human beings, white human beings, student human beings, poor human beings, and senior citizen human beings – the people. The pain of this present approach affects people, and it affects some of us more dramatically than others.

To deal with this question as a question of the human condition forces all of us to lift the level of debate beyond partisanship and beyond our narrowly construed interests and considerations to the universal need for comprehensive health care for all people for all time. I join you in that effort.

DR. THOMPSON: There is not much else to say, is there? Congressman Dellums has not only explained some problems with the formulation of public policy in this country, he has reiterated to us that we have to deal with our health, and that builds on what was said earlier – that health is more than medicine. And it is more than clinical work. As attendees to this conference, you might want to obtain the National Health Services Act and read it before criticizing it. I think that many people are being critical who have not had an opportunity to examine it. They have just heard a few people with vested interests who have spoken out against the bill. So I would suggest that you take a look at it.

Dr. Cain, I would like for you to tell us a little about what we should be doing in the arena of health planning, so that we can begin to do some effective formulation and implementation of health policy. Dr. Harry Cain is the Director, Bureau of Health Planning and Resources Development, Health Resources Administration, USDHEW. I am sure many of you know about the Health Systems Agencies, and about the State Health Coordinating Councils. These agencies, including other groups, come under the auspices of Dr. Cain's bureau. Dr. Cain.

■ *Harry Cain, II, Ph.D., Bureau of Health Planning & Resources Development/DHEW*

DR. CAIN: Thank you. I am quite pleased to be here and to have heard what has already been said. I will start by saying that I am a Federal bureaucrat in HEW, headed by Secretary Califano who in turn reports to President Carter. As Secretary Califano and President Carter haven't yet decided what kind of a national health program they would propose, it would be inappropriate for me to comment on Congressman Dellums' proposal except to agree with quite a few of his criticisms of the existing health care industry. Whatever comes out in the way of a national health program, I have to argue, will require sound planning, community based planning in which health care consumers are in the majority position. I am here to talk about the health planning program now being established around the country.

I will try to do three things: (1) to provide a quick overview of the program's current status; (2) what appear to be the changes ahead for the program as the Congress reviews, and changes, and extends it from 1978; and (3) to say something about the national attention to containing rising costs in the health industry, with particular attention to an HEW item published in the Federal Register on September 23 called "National Standards." Taking a look at the first item, I am pleased to say that the courts have consistently sustained the health planning program against a wide range of attacks, and it does appear that the program is here to stay. On the second item, almost every major interest group in the country is now participating in this health planning program in one way or another. A few of them are throwing harpoons at it, but they are paticipating, and that I think, is healthy. On the third item, I think it is clear now that the health planning program has enough support in the Congress and in the Executive Branch, that with a few changes and improvements, it will be extended next year. In HEW we are still having some problems in the implementation of the program. Most of these problems deal with the rules that we still have to issue. But I am glad to say that these problems are ~~not~~ holding up operation of planning agencies around the country that have already started.

The country is now completely covered. There are some 212 health planning areas and a planning agency is now operative in each of these areas. On the subject of how extensively black Americans are participating in the health planning program, they do quite well. According to our current statistics, blacks are well represented on the

HSA's, the health planning agencies and the governing boards. They have particularly high representation among the consumer majorities but are not so well presented among the professional health planning staff in these agencies. I think that may become a real problem to which HEW must devote some attention. The health planning agencies in all of these communities around the country, I hope you understand, are established to determine what kind of health care system they want that will respond to the health problems peculiar to those communities. This program has been established such that if it works well, subsequent regulatory decisions will be consistent with the plans written by these communities.

It is clear, as I am sure you have heard, that blacks in this country do suffer to an exceptionally high extent from certain kinds of health care problems, and they tend to be health problems that could be handled through the health care delivery system if that system were adequate in all the communities around the country. I have here a publication that has just been released by the Health Resources Administration, of which I am a part. It is a chart book that presents all of the available statistics on the health status of the disadvantaged in this country. The health problems that are afflicting blacks to an exceptionally high extent are quite well presented in this publication. It is called "Health of the Disadvantaged," and has the Publication Number DHEW 77-628.

Now, what are the changes ahead in the health planning program, changes that will probably be decided upon by the Congress in the next session? There are perhaps 100 proposals for changing the program, but it is our strong impression that while quite a few changes will occur, they will not affect the fundamental structure of the program as it now stands. The changes will probably accomplish raising the level of federal support for health care, which will probably go up about 75 cents per capita. Incidentally, we are now spending about $600 per capita on health care. Adding 75 cents to that doesn't seem out of the question. The changes made by Congress will probably increase the role of the health planning agencies in trying to contain the rising costs in health care. Several of the cost containment proposals that are now under consideration in Congress include a role for the health planning agencies to play. This will permit the scope of the certificate of need programs to include expensive equipment in ambulatory settings and will perhaps include, although this is not as clear, expanding the concept of the appropriateness review responsibility that the planning agencies have. You probably know that the planning agencies are charged now with reviewing all of the existing institutional health care services in their areas and publishing the results of those appropriateness reviews. But there are no sanctions applied if some particular institution is found to be "inappropriate". I think that Congress will reconsider that next year. There are a host of other changes I envision, but those I have just mentioned are the more central ones to what your interests probably are now.

In view of the time, I will discuss just a few of the things about the new proposed regulations issued on September 23. If you have not seen them, they propose to establish new national standards for some institutional health care services. These new standards would say that any health care area and any health planning area should not have over four acute care general hospital beds per 1,000 population and that all of the hospitals in an area should have an average occupancy rate of 80 percent or higher. Areas and hospitals where those standards are exceeded must somehow close that excess institutional capacity. It is not clear how they would be closed, but that is the implication. The new standards would also say that if a hospital provides obstetrical services and it is a hospital in an urban area that has a population of over 100,000, then that hospital's obstetrical services should handle at least 2,000 obstetrical services each year, or should not continue to operate. There are a variety of exception clauses, and I have sent these exceptions along with the proposed standards to every planning agency in the country. I have asked for their reaction as to how the standards would impact on health care in their community. We are now starting to hear from some of those agencies and other concerned groups. We have certainly caught their attention.

I think that HEW will review these public reactions with real care, and will undertake to change the standards wherever it seems required. Then in the early part of next year the standards will come out as final rules, and planning agencies will have to adhere to them if they do not have a persuasive case as to why one or another standard is not appropriate in their locale. Now, the Secretary has said, and the Planning Act requires, that several other areas pertaining to prevention, rehabilitation, concerns with access, et cetera, will also propose a set of national standards in the near future. When all the proposed standards have been made public, I think you will find that considering them all together, they will provide the clearest statement this country has regarding what its national health policy is. It really is essential then that everybody pay attention to what HEW proposes and react.

It is planned – it is essential, in fact – that these national standards be reviewed and revised each year, because they are clearly not based on hard science. We do not have a science that will support national standards. We have to review the available statistics and come to some reasonable judgement with which other reasonable people can argue, but it is clear that such standards are what the Planning Act requires HEW to issue. It is essential that the public watch what we are up to.

I would just conclude with two probably obvious comments on the widespread national concern for cost containment. Clearly, this set of national standards that just came out is aimed principally at cost containment. It is a two-edged sword. It is quite possible that the pursuit of containing rising costs could begin to hurt access to health care. On the other side, if we cannot contain the costs, we cannot extend the access. Handling that two-edged sword in this country right now is probably the highest challenge we have. HEW cannot handle that without extensive support. If some of you want to talk about that when we come to the discussion period, I hope you will. Thank you.

DR. THOMPSON: Thank you very much, Dr. Cain.

PLENARY SESSION III

TOPIC III: THE BLACK ADMINISTRATOR IN THE HEALTH POLICY ARENA

MODERATOR

Theodis Thompson, Ph. D., M.P.A.

..............................PANEL..............................

- **John L.S. Holloman, M.D.**, Past President
  New York City Health & Hospitals Corporation
- **James Haughton, M.D.**, Executive Director
  Cook County (Ill.) Hospitals Governing Commission
- **Arnett W. Mumford**, Administrator
  Southwest Hospital, Atlanta, Ga.

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SUMMARY OF PANEL PRESENTATIONS

TOPIC III: THE BLACK ADMINISTRATOR IN THE HEALTH POLICY ARENA

Dr. John Holloman opened the session with a summary of the lessons he learned in his tour of duty as President of the New York City Health and Hospitals Corporation. According to Dr. Holloman, the system is controlled by money and politics, with delivery of health care services a secondary objective. Dr. Holloman particularly addressed himself to the students (future administrators) in the audience, and urged them to be diligent in learning how politics works, for only in that way can administrators acquire real power over the systems they administer.

Dr. James Haughton, of the Cook County Hospitals Governing Commission, set a more positive tone in talking about politics in the health care system. According to Dr. Haughton, political leaders are ready to listen to sound technical advice if it is presented properly. He backed up this contention with several examples from his own career. Dr. Haughton described these examples, ranging from state-level abortion legislation to federal cost-containment proposals, to support his thesis that to have an impact, the administrator must know his field, offer his services, and cultivate politicians with care and finesse.

The third and final contributor was Arnett W. Mumford, Administrator of Southwest Community Hospital in Atlanta. Mr. Mumford, speaking from his experience in running a small community hospital, suggested that success in such a position involves promotion from within, training well, treating people with respect, and managing democratically. As far as external connections are concerned, Mr. Mumford stressed the importance of working with elected black officials (and working to see that blacks become elected officials), as well as working with and through such organizations as the National Association of Health Services Executives.

AUDIENCE QUESTIONS & ANSWERS FOR PANEL III

MS. MILLER: I have one question. The panelists seem to have defined power differently. One of them sees power as money. That's Dr. Holloman. One sees power as information. That's Dr. Haughton. And one speaks of it as people, as I understand Mr. Mumford.

Can either one of you speak to combining these three definitions so that black people can use them all to acquire more power – i.e., to get more power in planning health policies for blacks?

DR. HOLLOMAN: I think power is stratified, and I think that in this country ultimate power is money. I think the effect of communities, such as community support of policy, community support of administrators, and community influence on politicians, is essential. But when we have an entrepreneural system, when we have a health policy that makes health a commodity which is still for sale in the competitive market, we are dealing with the ultimate power, which in my opinion, is still money. I think that the power which exists in this country can probably be best seen if we look at the Fortune 500 Corporations. I think we will find that here is where most social policy is ultimately made.

We have watched the situation of blacks since 1619. We've watched the major war. In fact, we've watched a number of struggles. That is why I bring you this little pamphlet on the Bakke Case, so that you can begin to rally around it, not that you have to do anything except to be informed on the issues. I urge you to be informed there. But if you're going to make power in your local community, you've got to, as Dr. Haughton says, influence the only game in town to the extent that it is currently possible. I am suggesting then, that there are some system changes which are necessary if we are going to make health care a right.

DR. HAUGHTON: I'd like to comment that the three things you mentioned – money, politics and people – are not mutually exclusive. The skill is to learn when to use which and in which combinations. When I went to Chicago seven years ago, I used to go down to the County Board once a year with my budget all by myself. When the Board of Education's budget was on the docket, the rafters were full. Health and Medical Care had no constituency. I began seven years ago to build a constituency. Now, when I go down with my budget, the bleachers are filled, because we have tried to take our services to the people through the people.

We are in the process of developing a health care network and we now have five neighborhood health centers. We will not start a health center in a community where we cannot find a community group to work with us, so that every one of our centers has a community board with a joint policy committee composed of members of that board and members of my staff, and we do nothing in that center that has not been approved by that joint policy committee. So we do work with people because people are power. But then there are times when I need to go down to Springfield and deal with the people down there, and if it is a piece of legislation that somebody else has proposed, I deal with that issue.

When I have a piece of legislation that I need, that I submit, I make sure I package it so that there is something in it for the people I'm selling it to. Politicians support or oppose legislation for their own very private reasons. If you want their support, you've got to learn how to put it together so he, the politician you are talking to, sees some benefit to him in that package. So information is power. People are power. Money is power. Politics is power, and sometimes you have to put them all together.

MR. MUMFORD: Relatively speaking, I don't feel the black community really has any money. Those of us who do have money for health care, can go to the white medical centers, the white specialists, et cetera, to get our health

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care. So when we talk about health care policy, we're essentially talking about formulating a policy to protect the interests of those who can't buy that top 10 percent of quality care in the country.

Now if you start with the premise that we don't have enough money then we are forced to find some other way to influence national health care policy. I see us effecting a negotiating base the same way we did in the '60s with civil rights. The only thing we had then was people. That is why I feel now that the solution is people - large masses of people, as well as influential individuals in key positions in the community.

Right now, it seems to me that there is very little response from the black community in terms of what's happening in health care, or for that matter in housing, education, or any other area. It is amazing to me that we sit idly by and see things happening around us, yet lack the motivation to get organized and take action.

DR. THOMPSON: Dr. Kerr, did you have a comment?

DR. KERR: I would like to add a little more note to this. I've known and worked with Mike and Jim for many, many years. In all of my many years of administration, I've come to realize that to get the things that you and I and others want to have done, we must build a countervailing force to the forces to which Mike addresses himself, which, by the way, are here for quite awhile longer. They're going to outlive you and me together, Mike, and then some. But nevertheless, in order to accomplish what you want to see and what Jim is doing and what you're doing and what I'm doing, we have to organize and become united; there are a lot more of us who vote than there are people who run banks. So we must join together, both the black community and the trade union movement. One must have a base from which to operate. For example, when I go up to Congress and testify, I'm testifying on behalf of the Mine Workers and as the only trained physician in the whole of the trade union movement. So I can speak from that base and have an impact on legislation that others might not have. But I also believe that all of us must work together – trade unionists, blacks, and other medically deprived minorities; we need each other desperately.

MR. LOADHOLT: Loadholt from the Greenpoint Hospital Community Board in Brooklyn, New York. I would like to, first, thank Dr. Holloman, Dr. Haughton and Mr. Mumford for the statements they've made, but I don't see anyone sitting on the podium from the community. This is very bad. Now, Dr. Holloman knows himself that any time the most powerful corporation in the world, the New York City Health and Hospitals Corporation, needed any input, they had to come to the community. But yet whenever everything cools down they forget the community completely. This has got to stop. If you want to deal with the problems, you must let the people know what the facts are. New York politicians are different from any politicians in the world. There is no other politician in the world like the New York politician, because in New York we have black people politicians and we have nigger politicians and we must deal with that fact. So from now on, on any podium that we have, I would like to have some community representation. (Applause).

DR. THOMPSON: Mr. Mumford might argue that point and say he represents the community; I have not asked a question and I would like to take this opportunity to do so as we wrap up the session.

It seems to be a very important issue that what we tend to respond to is from what we read and what we see and what we hear, particularly on TV and from other influential media. What do the media highlight and what do the media emphasize? I'm never sure of what kind of issues they are focusing on. They tend not to focus on health, but on issues that are social and economic, leaving out the health components of such issues. I think media representation is something that we ought to look at and be concerned about; blacks don't have much influence in the media. I would like to ask the panelists – I know that you have had some experience with the media – what kind of influence do you see the media having, not only in health, but in terms of the black health administrator's survival?

DR. HAUGHTON: The press in Chicago is a very unique instrument. The things that they write about are not even considered news in most parts of the country. I have found a very interesting situation in Chicago. Whenever they send somebody to interview me, it's always a white woman, most of the time anyway, and she devotes the first paragraph of her article to something unimportant like the way I dress. That's how the media can be. On the other hand, they are opinion makers, and so even when you don't like them, you can't ignore them. And even when you give them information, they can present it in such a way that people will not know what you said to the newspaper. There is one set of papers in Chicago that can always find a negative way to tell a positive story. No matter how much you say to them and how clearly you present the facts, they can always tell a negative story. In my own experience, I have learned to deal with the press that I can deal with and to ignore the rest–not ignore in the sense of not giving them information, but not losing any sleep over how they present what you give them.

When you find press you can work with, then you make a real investment. If you could look at the editorials that have been written in the Chicago Tribune about our organization in the last six months, you will find that every one of them was at least fair. Most were very good, but that didn't happen by chance. When I think there is an issue that the press is going to editorialize about, I make sure that the Tribune, which is the most respected paper in town, has all the facts. In fact, I have spent many hours in the offices of the publisher and editor, and the senior editorial writers of the Tribune, not telling them what I want them to write, because they won't do that, but at least making sure that they understand the issues and that they have all the facts that I can make available to them. Most of the time I end up with at least a fair editorial, not always laudatory, but always fair. So I think that we have to deal with the press. We can't ignore it. But please don't be thin-skinned, don't get mad at them and try to ignore them, because they can really cut you down. Learn to work with them, expect unfairness from some, and put your biggest investment into those you believe are going to be fair. That's my experience with the press.

DR. HOLLOMAN: I think that Mr. Loadholt's statement about New York politicians could also be applied to the media in New York City, particularly the press. One of the most widely read newspapers in the country, the *New York Times,* publishes several international editions so it is read pretty much all over the world. And the Times has a slogan, "All the news that's fit to print." I think that many New Yorkers, particularly the poor and minorities, have found that "All the news that the Times sees fit to print" is more accurate. They really print what they want to, and like some of the other newspapers in town, they editorialize the news. What Jim was suggesting was that many times the reporting can reflect an editorial point of view. If a reporter can find something negative, many times what is printed in the paper is extracted from a larger presentation, and that which is positive finds its way to the cutting room floor. News headlines are many times taken out of context. The importance of Jim Haughton's mode of dress is certainly front page news in the fashion world, but I don't think it really influences health policy very much. The important thing to remember about New York press is that New York, during the past four years particularly, has been a major and very serious recession, and the fate of New York City is still very much in doubt, although any decision about its future will probably be delayed for at least another two years. Next year is a gubernatorial election year so you can be sure the governor is going to promise everything and appropriate money for everything after having participated with other politicians in the rape of New York City.

That rape by the banks and by the Emergency Financial Control Board was very real. We hear a lot about retrenchment, but you'll find that retrenchment was carried out in New York City at the expense of minorities and the poor.

The people who lost jobs in New York City were poor people. Health and Hospitals Corporation lost more than 10,000 employees in the space of 18 months. The Police, Fire, and Sanitation, which represented the uniformed forces, were supposed to be participating along with the Board of Education in those reductions. But if you look very carefully, you'll find that the firemen have been back up to full strength, and even higher, for more than a year. You will find that the police lost only some of the projected increases that they were getting in their strength. But there were 10,000 people who were working in Health and Hospitals Corporation who are no longer working. Yet the press still insisted on blaming the fiscal problems of New York City on the fact that the health budget for the Health and Hospitals Corporation was relatively large. The press ignored the fact that most of the Medicaid money that was expended in New York City was not expended by the Health and Hospitals Corporation, but by the voluntary institutions, the voluntary hospitals and private physicians of New York City; no where will you find that clearly explained in the press.

When we talk about excess hospital beds, the Health and Hospitals

Corporation lost 3,000 beds through voluntary decertification, but whenever there are closures called for, the closures are called for in inner city areas. Closures are not called for in the private health empires that are continuing to expand. At the same time the press talks about 5,000 excess beds in New York City, the State Commissioner of Health is sitting on approvals for the construction of 7,000 new hospital beds. But those new beds are in upper income areas. Whenever a politician needs a headline-grapping issue, he can pick on health, particularly Medicaid because it is viewed as a program for the poor. Issues such as health, welfare, aid to dependent children, and now even on the national scene the denial of the federal financing for abortions, are good issues for politicians, and some of them can even be moralized about.

But that's not where the money is wasted. The money that would be expended on an abortion is a very small amount when you consider how much money it would cost to deliver a child and to raise that dependent child to adulthood on welfare. A welfare potential is not something that is inherited. Welfare potential is something that's generated by a system that does not provide jobs for all workers. It is generated by a system that is dependent on a high percent of unemployment. If it were not dependent, we would have had full employment a long time ago. But the only thing we get is political double-talk about full employment.

So I urge you, when you read the press, to recognize that the press is not impartial; it is in fact completely controlled. In New York City, I would have reporters come in to me and say, "Dr. Holloman, if you don't want to talk, you don't have to, because we have been instructed to write a derogatory article about the Health and Hospitals Corporation, and that no matter what you say, the article is going to come out derogatory, because the policy has been decided." These are reporters that I am quoting. So when we talk about the power of the media and the press, it's very, very real. If you want to know what the picture is going to look like, if they can find an ugly picture of you or a picture where you are doing something horrible, you can tell that this is the picture that will appear. And when a politician is in disfavor, they'll show the ugly picture, and of course, when he is in good favor, he'll look like he is 20 years younger and he'll always be doing something good. So let's watch the news that's editorialized before it is printed. We do not have an impartial press.

DR. THOMPSON: It is about time to wrap up this session. To Arnett, to Jim, to Mike, thank you very much.

And to you, the audience, you've been very patient with us and we hope to see you at dinner at 8:00. Thank you.

PLENARY SESSION III

TEXT OF PANEL PRESENTATIONS

THE BLACK ADMINISTRATOR IN THE HEALTH POLICY ARENA

DR. THOMPSON: "The Black Administrator in the Health Policy Arena," is probably one of the more interesting topics, as well as one of the most controversial topics. It surely is a topic where we have seen some interesting happenings in the last few years. We have some very good examples among our panel this afternoon. They are not only excellent, dynamite health professionals and internationally and nationally known, but also have some very good experiences to share with us.

Dr. John L.S. Holloman, affectionately known as "Mike," has been around the health field working in an advocate role for years. He is Past President of the National Medical Association and of the National Committee for Human Rights. He has been listed as one of the top administrators in the world by *Black Enterprise* magazine during his tenure as head of the New York City Health and Hospitals Corporation, the largest such corporation of public hospitals in the world. Many of you know Dr. Holloman, and if you don't, you'll know him well by the end of the session.

The distinguished gentleman next to him is considered to be one of the best administrators in the country and is also one who acknowledges the fact that, although he is an M.D., he understands that management skill is very important in the operation of health facilities. He points that out very well by saying, that if you're going to be a manager and administrator, you had better go and get some management training and learn how to deal with the procurement and allocation of health resources. He can talk to you about his experiences in many aspects of decision-making in health management. For example, if you want to know anything about labor relations in the health industry, you're talking to one of the most dynamic people around. He's also considered to be one of the most controversial hospital administrators in the country. I am speaking of Dr. James Haughton, Executive Director, The Cook County Hospitals Governing Commission, Chicago, Illinois.

Mr. Arnett Mumford is one of the brightest and most astute young administrators in the country. At a recent conference in Atlanta, Georgia he received the Young

Administrator of the year Award from the National Association of Health Services Executives (NAHSE). He also has an efficient operation going at his hospital in Atlanta.

So you have before you a selection of excellent hospital administrators who happen to include physicians and non-physicians. Therefore, we can deal with a cross-section of the issues in health policy, specifically those related to experiences unique to the black health services administrator.

■ *John L.S. Holloman, M.D., Past President NYC Health and Hospitals Corp.*

DR. HOLLOMAN: Thank you very much. It is indeed a pleasure to be introduced by a person who is either neutral or a friend, having experienced hostility, both overt and covert, from those who have other persuasions.

I am happy to be here with you all and to see so many friends in the audience. It's a real pleasure. It's also, for me, a pleasure to say a few words about another organization that deserves your support, and that's NAHSE. I think all of you who are supporting that particular organization are doing the right thing, because we have great need to combine our strengths and to utilize whatever methods are necessary to overcome some of the difficulties that are there.

I see, also, in the audience, a number of future executives, a number of students. I even committed myself to go to Harvard University in the spring just to be with the students there. So I am very, very delighted with this particular session. Now, having said all of the nice things, let me tell you how it really is. I think, first of all, we are in a big game. Health care and the administration of health care is probably the name of the game. We have a health industry which is going to be involved in something that would exceed, this year, $150 billion. That kind of money will make a lot of people do a lot of things that do not necessarily relate to what we are supposed to be about. Some of my recent experiences in the City of New York enable me to give you chapter and verse of the behavior of some of the largest organizations in this country, certainly in the largest city in this country.

Now the problem of being a black administrator is quite similar to the problem of being a black Ph.D. Who knows what they call a black Ph.D? For those of you who don't, it's the same name that Dick Gregory uses as the title of his autobiography – *Nigger*. You will find now though, that you are not called names quite as overtly as you may once have been. But the removal of the element of racism from the situation is something that has not yet happened. The issue comes up in many subtle ways that you may not be aware of. The first challenge will be to qualification, and you will be qualified and qualified until you are overqualified, and then the challenge will be that you are too qualified for the position. It happens that to fit exactly into a position can be an extremely difficult job. And once hired, the black administrator is very frequently involved with decisions that touch on the lives of many people. The health care industry probably employs more people than any other industry outside the federal government. Certainly it is among the top three employers in the country.

It is particularly important to recognize that while until now the professional provider has been the most important person in the health care industry, the administrator will be the most important person in the future. The technological advances have been made, but the sociological advances have not been made. We have the technology, but we do not have the distribution system. We have many advances that never reach the people who need them most. Health care in this country is badly distributed, badly administered, and far more expensive than it needs to be. Recent attempts at social legislation have done very little but create additional problems. We enfranchised for health a few older people and then simultaneously disenfranchised them through the mechanism of inflation and through the very clever devices of co-insurance and deductibles, so that Medicare now costs many of our elderly citizens on fixed incomes more money than they were paying for their care prior to the event of the Social Security Amendments of 1965, Titles XVIII and XIX. With this type of escalation in cost and with this decrease in services, we realize that we are, as consumers, caught in a bind, and as administrators, often blamed for the high cost of services.

Very often the control of those services does not lie with the administrator. I say that because those of you who don't know about the game of politics would do well to learn what politics is all about, and to learn that politics (this is not a definition) is the art of double-talk with a sugar coating, and he who can double-talk most very often turns out to be the person with the most power. However, when we talk about politics, we must also be particularly careful. I use the word "particularly" again and again, because I am trying to emphasize the fact that you must pay attention to *details*, because those things that you may sometimes consider unimportant

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will be used to hang you, particularly if you come into political disfavor. Now, politics in this country really is a strange game, because it makes no difference what political party is in power; the differences between the two parties are minuscule. The control in this country does not rest necessarily with the politician. The control of politics and the control of policy in this country rests with those individuals who control the purse strings. It is certainly a minority of the people in the country, probably fewer than 3 percent of this country who are calling the shots as far as our health care delivery system is concerned. If we look at the Fortune 500, we might have some idea as to who dictates policy. If we look at campaign contributions to our elected officials and our Congress you will be able to predict with a great degree of accuracy exactly how they are going to vote on certain issues. You will find that the insurance industry, the banking industry, the Political Action Committee of the American Medical Association, and other such groups are major contributors to the war chests and campaign funds. Look at those contribution lists and you will be able to predict the way the vote is going to go. I'll give you an example of power and concentrated power. Aetna Insurance and Morgan Guaranty and Trust Co., in just one block, control more than 13 percent of the gross national worth and wealth of this country. That's just in one block. Now, if you think there's going to be any altruistic, moralistic or any other revolution, you have another think coming. I would suggest to you that we're going to see the damndest bit of shenanigans going on during the debate about National Health Insurance – which should begin in earnest during the coming year – that you've ever seen.

One of the things that we have failed to confront with any degree of intent is to make significant alteration in *the* system in general, and one of the facets of this system where major confrontation has not occurred is the health care delivery system. Each time we have approached that problem with piecemeal legislation through the political process, we have added other vested interests that really dilute and delay the day in which we can have a health care delivery system that is designed to meet the needs and the situation that confronts every poor person. In fact, every person who is a consumer of services in the American health care delivery system is really affected. We have watched since 1929 or certainly in the early '30s the development of the Blues (Blue Cross- Blue Shield) starting, I believe, at Baylor University in Texas, spreading to Houston and, I think, very quickly to Dallas. We should recognize the fact that prior to the Blues, there were railroad and mine workers who had prepaid plans for their workers many years before they came into existence. But controlling and vested interest groups will have you believe that the Blues are absolutely essential, and that we could not deliver health care without them. We have many other very, very powerful blocks, all of which add to the cost of health care and do not necessarily expand services. We have seen the spread of so-called Health Maintenance Organizations. I say "so-called," because they will maintain health only to the extent that the money you have to provide will permit them to last as operating organizations.

In a country such as we have, in which health is allegedly a right but is in actuality a commodity sold to the highest bidder, we have a dichotomy and we have a problem. If you approach it with pure rhetoric, you are certainly doomed. You are doomed to great disappointment. If you approach it with pure idealism, you are doomed to great disappointment. So I would suggest and advise all of you who are early in your careers, to learn the game, to know where the truth lies, to dig through the superficial coating, to ally yourself with those health statesmen who may be around – and there are some – to ally yourself with those providers who recognize more than rhetoric in the slogan that health care is a right. I urge you to arm yourself so that you will not be disappointed and so that you cannot be derailed or thrown off the track too easily, but know the score, know that health statesmen are few, that health politicians are many and that health is, at this point in time, a big business. I can tell you, and this will shock you, the waiting time after triage in some of the hospitals, such as in New York City, can be as long as four or five hours; in some instances, longer. That's in an emergency room. It is because of the health care delivery system that the misuse of emergency rooms is allegedly associated with poor administration. Such misuse could, perhaps, be corrected if the administrators had the power to correct it, but they do not.

I was in Botswana a number of years ago where we were challenging apartheid in Southwest Africa. There I saw a worker who was critically injured. He had a piece of steel driven into his skull. The flying doctor service got to that man within two and half hours after he was injured and transported him to a hospital. I've been to Europe, and I've watched NATO helicopters transport patients to hospital facilities from all over Scandinavia in a much shorter period of time than it takes us to treat a patient in some of the emergency rooms of our inner city hospitals. Earlier this month, I was in the People's Republic of China, and I saw with my own eyes a health care delivery system in which every person knew his point of entry. Although the system in certain parts may not be as technologically advanced as ours and they are still busily combining traditional Chinese medicine with Western medicine for a so-called new Chinese medicine, there is the feeling that there is a system that, as Vic Seidel says, "is to serve the people." There are other systems in the world that are probably less geared to entrepreneurship than the system we have, but I will not discuss them now.

I will tell you that the situation in New York will be the subject of a monograph and perhaps later on a book. So I won't tell you all the intimate details now, because I hope that you will buy my book, or certainly read my monograph. But I can tell you that the name of the game is certainly not health care delivery, but the name of the game is money. When you see as I did, religious organizations and large provider organizations fighting like alley cats and dogs, fighting with all the viciousness as you can imagine, not to serve people but just to garner city funds, or to garner tax dollars, and when you see state Departments of Health trying to steal for priviledged groups, or institutions, you are shocked. Perhaps, as in my own personal experience, you are satisfied when you get a decision from the Supreme Court which suggest that the Commissioner of Health is arbitrary and capricious in denying an operating certificate after having created a fiscal problem for the corporation, it may cheer you. But that doesn't change the name of the game, and on election day you don't necessarily change the name of the game. You very often simply change the characters. So as administrators, and as future administrators, I urge you to do the things that are necessary, but at no point in time, as long as you are a health administrator, and as long as you are in the business of administrating, remember that the most important person in a health care delivery system is the patient. Nothing personal can be so important as to let you forget that important charge. Thank you very much.

■ *James Haughton, M.D., Cook County Hospitals Governing Commission*

DR. HAUGHTON: I bring a slightly different perspective than my brother John, because, perhaps, I have been more fortunate in the political environments in which I have worked, even though I did start my administrative career in New York. Unfortunately, in too many of our large metropolitan centers, black is synonymous with poor, and since it is the poor who are most often affected by human services, it seems to me that it is incumbent upon all black human services administrators to be concerned about the means of influencing policy. Particularly in the health industry, policy can mean the difference between life and death for many people. Unfortunately, in spite of what you heard in the previous session, there is no mechanism in this country for establishing health policy. I heard Dr. Cain say that, when HEW completes its set of standards for HSA's, that they will be the most complete statement of health policy for this country. That is hardly policy, and because there is no mechanism for establishing health policy, policy is made in the political arena by default. Therefore, we must learn to use the political arena. Now, John has given you a very jaundiced view of the political process, and he is absolutely correct, but it is the only game in town and since it is, we can't stay out of it.

The black health administrator, therefore, must find ways of influencing policy. Permit me to give a few personal examples of how this might be done. Sometimes we think that we have won something when we have impacted the legislative process and we've gotten a piece of legislation passed. The fact is, frequently that is only the beginning of the battle, because a hostile administrative agency can develop regulations that will so clearly violate the legislative intent that what you fought for won't be worth the paper it was written on. Therefore, you must find a way not only to impact the legislative process but must stay with it and impact the rule-making process and the implementation of the legislation for which you have fought. In my own experience, I have found it necessary to work with politicians. I do not start from the posture that all politicians are crooked and that the whole political process itself is pejorative in its objectives. Too much of what affects our lives happens in the political arena for us to stay away from it, and so I have started with the assumption that every powerful politician wants to do the right thing, only he doesn't know what the right thing is, and so he needs us to tell him. We have expertise that he doesn't have. No politician is a specialist in everything, and yet we expect them to sit in the halls of Congress and the halls of our legislatures and in our city councils and develop legislation that addresses itself to the issues that concern us. They will never be able to do that unless we share our expertise with them. When I arrived in Chicago seven years ago – and this week I begin my eighth year in Chicago – I took it upon myself to learn what Chicago politics was all about. I had always heard about the machine and about the Chicago Democrats and all of that kind of thing, always in a pejorative way. But over the last seven years, it was a very comforting thing to know that even though I didn't work for the City of Chicago – my agency is an independent county agency – if I went to Mayor Daley with a proposal that I thought was good for Chicago and convinced him that it was worth supporting, only God could overrule him. That was very comforting to know. Therefore I took it upon myself to learn my way around the political process. I soon became an advisor to the President of the Senate. I met him socially, offered my services to him, not to tell him how to vote, but to explain health issues to him. And until he left the Senate this past year, there was no health legislation that went through the Illinois Senate which he had not discussed with me and had heard the alternative issues, never with any recommendation as to which way to vote, but to make sure that he understood clearly what issues were at stake. A number of pieces of important legislation have passed in Illinois. Some of my colleagues give me credit, because I think it was part of my job to make sure that those people who had to vote and had to take powerful positions understood the issues underlying the positions they would take.

There are also organizations that impact on legislation and impact on political decisions, and it is incumbent upon us to participate in those organizations. For the last five years, I have served on the Board of the Illinois Hospital Association. There is very little health legislation that goes through the Illinois legislature that does not have the support of the Illinois Hospital Association. They write much of it. They seek sponsors for it, and those sponsors listen to the Hospital Association. I had to find a way to impact that organization, so I worked my way onto the Board. At the executive level, the people who must implement legislation need help and they, too, need the advice of those of us who work at the level where services are delivered. We must find ways to make them listen to us. We must offer them our assistance; we must make sure that they understand the issues underlying the legislative intent, or they will administer programs in ways that do not serve our people well.

Only a month or so ago, the Governor of Illinois vetoed the anti-abortion law passed by the Illinois legislature, a bill now which denies women who cannot pay for their own abortions the right to have them paid for by the state. This bill would prevent the state from using state funds to pay for abortions. I have come to know the staff of the Governor, and at the time that bill was passed, in fact, while it was still in the legislature, I wrote a letter to the Governor, which did not get into the issue of the morality or immortality of abortion. I am a physician and a manager and I need not concern myself with that issue. What I did point out to the Governor in my letter was that such a law will not prevent abortions nor will it save money. I assumed that those were the intentions of the bill. I sent him a paper with documentation of the terrible consequences, that a member of my staff had written some years ago about Cook County Hospital's experience with incomplete and septic abortions caused by backroom practice. I pointed out to him that all that the bill would do and all that the law would do if he signed the bill would be to change the kind of abortions that poor women received. Two weeks ago the Governor vetoed that bill and quoted my letter in his veto message. This is the way I believe health administrators must find a way to impact on policy because there is no current rational mechanism for the creation of health policy in our country. As I said at the outset, policy is now made in the political arena both at the legislative level and at the administrative level. We must find ways to bring ourselves to the attention of those people who will make these decisions and bring ourselves to their attention, not by criticizing them but by offering them assistance. I have yet to find a politician who refused to listen when I offered to discuss an issue for him.

We frequently provide poisition papers to various legislators and to committees of the legislature and to the Congress. Most of the cost containment bills that are now in the Congress were sent to me before they were introduced, for comment, while they were still in draft. I tell you all of this not to tell you that I am great or any of those things. I merely wanted to give you some examples of what processes are there. They are there and they are open to you only if you will take advantage of them. And the way for you to take advantage of them is to offer your services. Those people in the legislatures and in these other kinds of bodies do like to look good sometimes. They like to do the right thing. They often don't know what the right things are. As John (Holloman) pointed out, there are many powerful interests out there trying to co-op them, co-op them in some very vulgar ways like the contributions to their compaigns that John mentioned. But we must find a way to counteract those pejorative activities, and I think that one of the best ways to do so is to provide these people with the knowledge, with the understanding of the issues, the facts, and then at least, you will know that, if they did not deal with the facts, you now know that you are dealing with dishonest people. But let's not start with the assumption that they are dishonest, and so as my final thought, I would say, if you don't become a part of the action, you are destined to be the constant victims of the action. Thank you.

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Arnett W. Mumford, Southwest Hospital, Atlanta, Ga.

MR. MUMFORD: It is hard for me to understand how a light weight like myself got to follow these two acts here. It puts me in a bad spot. After all, I should have had first crack at making my presentation. But I certainly enjoyed your comments, gentlemen, and my comments come from a little different perspective because I am an administrator of a small black hospital of only 125 beds.

As I understand it, most of the black hospitals in this country – and when I say "black", I mean traditionally black hospitals that originated in the black community, and are still black hospitals – are in a great deal of trouble. This trouble emanates primarily from the fact that small hospitals, white or black, have great difficulty surviving in a highly political environment. We have heard comments about the vicious fights that are going on between the large heavy weights for the money that is available. After all, when we talk about health care in this country, I think all of us recognize that it is a question of money rather than a question of right. So when I approach the question of what is the role of the black administrator in health care policy, I have to start from the standpoint of what's the origin of the black administrator and what's his philosophy on health care as a right.

As far as origin is concerned, I'm sure many of you in this room are old enough to recognize or to remember when hospitals were segregated. I can remember when my daughter was born how we had to go to the backdoor of the white physician's office and to the segregated ward in the local Louisiana hospital. We have come, certainly, a long way from there. Being a southern boy, I think it was the experience I had in large northern medical centers which gave me a propensity to return to the South and involve myself in the management of small black hospitals, hospitals with which I was more familiar. Having done that, and having been at a small black hospital now for five years, I have learned a few lessons that I'd like to share with you in terms of how my organization tries to impact on health care policy in our city, in our state and nationally.

All of you recognize that small hospitals, particularly black hospitals, have great difficulties in terms of finance, in terms of capital equipment and in terms of staffing physicians and RNs. We also recognize that all black hospitals, or I should say the vast majority of black hospitals, as well as other black institutions, do suffer from an image problem which hampers their reputation. Black hospital administrators like to cry on each others shoulders and talk about how a mistake in a white hospital is called an act of God and when it happens in a black hospital, of course, it is "them niggers messing up." It's something that has to be fought. So recognizing that attitude from my experience, as a young man and as an administrator, I've felt that my first concern should be what is the policy of the hospital or any hospital that I work in toward developing relations with its community and toward providing quality services, because without quality, you can't have good relations with your community.

At Southwest, we began with the problem of how do black people serve other black people, and what resources are available for that. We determined that our policy would be that our internal efficiency would be our first priority. Our policy would be directed in that area for the development of cash, capital and the training of individuals. The philosophy of management in the black institution, I think, has to be a little bit different. As far as policy of management in our hospital is concerned, we believe very fundamentally in the principal of democratic management or what is known as MBO. However, the experiences of hospitals in using this system of management is very primitive. A lot of people, including myself, have gotten into deep trouble trying to implement democratic management, but it can be done. It is my opinion that, in a black hospital, you can't get that tender loving care, or that high quality of service until the housekeeper feels just as important as the RN. That's been my experience.

So our philosophy is, if a manager cannot get that feeling of unity among all staff in his department, even though he may make a tremendous amount of money, then he is not the type of manager that we want. First of all, we try to staff our departments with people who have skills, energy and a common sense of the people. That's why we promote primarily from the inside. Our health care policy is to promote from the inside, train well, treat people with respect and manage democratically. Secondly we try to involve the community in that process. When we give disaster drills, we try to get as many members of our community to serve as fake victims as possible so they can see what happens when you come through an emergency room and go into the operating room, et cetera.

But, of course, you know that we have an education problem in the black community regardless of what kind of organization we are talking about, a hospital, a university or even a Kentucky Fried Chicken place, if it is not operated properly. We say that contact with organizations in the community, involving them in the creation of quality gives us the bases we need to effect policy on a city and on a state level. However, if the community does not feel as though a hospital is of worth or is needed in that community, the administrator's voice in the health care policy arena is like howling in the wind.

I believe it is important that we develop strong organizations first that mean something to the community. So when an administrator speaks, firstly, he doesn't necessarily have to speak through his own voice but secondly, if he does, he has strong community backing. Therefore the influence of a black hospital administrator, at least, in terms of small black hospitals is primarily based upon the influence of his constituents or the constituents of that particular hospital.

In terms of influencing policy on the city level and on the state level, which has become more important recently with the advent of HSAs, – our philosophy is that the only way we effectively do that is through the political process. In Georgia, there is tremendous effort in the black community to elect black officials. This has occurred with some degree of success in terms of impacting health care policy from the standpoint of the City Council of Atlanta, the State Health Planning Agency or the HSA for our particular area. Without the elected officials in our area, we would have very little impact on any of those agencies. So we not only believe in aligning ourselves with our staff inside our hospital, aligning ourselves with groups outside and surrounding our hospitals, but also with the elected black officials that represent our area and other black areas. Now, probably one of the key factors which permits us to affect policy in our region is the black physician. Persons in this role seem to exhibit the most powerful voice in our community. Even more powerful is the voice of the local medical society and its counterpart, the black medical society. As I understand it and from my limited experience with medical societies around the country, we have a fortunate situation in Atlanta, because the medical society is strong and it is political, and we have several physicians in that society who, I would imagine, could be considered more of a politician than a physician. But we need them and the reason they exist is because without their increased political role, the black community's interest could not be adequately protected.

We believe, and despite the fact that administrators and physicians have had a dog and cat relationship over the years, that we should not repeat the mistakes of our white counterparts and continue to pit the administrator of a hospital versus the medical staff of the hospital. We also believe in involving the medical staff in the democratic management of our institution because only in that way can we get the commitment and support of the physicians. My hospital is only 125 beds, but we stay 99 percent occupied on adult medicine and surgery, primarily because of the support of the black physician. We have white physicians, but as any hospital that is serving primarily a black population, the black medical staff is the backbone of it. We are fortunate in that our hospital is located in Atlanta which carries a special social and economic ramification. We understand that phenomenon, but we are fortunate in having occupancy, having medical staff support and increasing our voice in the policy of our city and in our state.

Now, the question of national influence. From my standpoint, I really do not concern myself as much with this area as my colleagues on the podium, who operate in a different kind of environment. But I am concerned about national policy, and believe that we can have impact, which can be effected through an organization which is primarily geared toward black people. NAHSE, as Dr. Holloman has mentioned, is such an organization. I take this opportunity to urge each of you to please support NAHSE because, in effect, it's the only organization where all blacks in the health professions can come together and develop dialogue which might influence health care policy that affects our community.

So I remind all of you here: quality first, because we do suffer from that image problem, and we do have a short history in the management of institutions, particularly those institutions like the one I represent that fell to blacks from white flight. We do have traditionally black hospitals, though, some of whose origins are in the segregated communities of the early '20s and '30s. I recall an article dated 1913 from the *Times Picayune*, the only newspaper in New Orleans then and even today. The article talked about the formation of Flint Goodridge Hospital and the Sarah Goodridge Training School. Accordingly the development of these institutions was a very good thing because finally as the article stated, there is somebody to take care of these poverty stricken darkies. But things have not changed much, and we still have to consider ourselves a separate and segregated society. For that reason, I think it is extremely important that hospital administrators serve as the focal point for a united front effort, a united front composed of people in all professions, educational institutions, hospitals, businesses, teachers, whatever, in having some kind of impact on the policies that are being formulated now. Such an effort should maximize the benefits that blacks receive. Really though, I don't believe that black people can change the basic elements of health care policy in this country any more than they can impact on policies in other areas. We just don't have the economic and political influence. However, we can get some changes that will protect us in the long-run. I think the Bakke case should be a signal or symbol to us for the necessity of forming a united front in health, in education, housing, and politics. Thank you.

DR. THOMPSON: I think we've had a pretty good overview of the black administrator in the health policy arena. Although we did not have a federal government administrator or an administrator who works in another area, some general issues have been presented here in talking about the black administrator in the health policy arena. It could be expanded on, and I'm sure when we get to the workshops, you will develop these issues, from your own personal experiences. Also, I think, any background issues and problems that you'd like to bring to the workshops, feel free to do so.

PLENARY SESSION IV

TOPIC IV: PROBLEMS & ISSUES IN THE FINANCING OF HEALTH CARE

MODERATOR

Paul B. Cornely, M.D., Dr.P.H.,

Past President,
American Public Health Association
and
Professor Emeritus, College of Medicine,
Howard University, Washington, D.C.

................................PANEL................................

- Dorothy Orr, Vice President for Corporate Social Responsibility, Equitable Life Assurance Society, New York City.
- Ruth Hanft, Deputy Assistant Secretary for Health Policy Research & Statistics, DHEW
- Sidney Wolfe, M.D., Consumer Advocate. Washington, D.C.
- Peter Fox, Ph.D., Acting Assistant Administrator, Health Care Financing Administration, DHEW

SUMMARY OF PANEL PRESENTATIONS

TOPIC IV: PROBLEMS & ISSUES IN THE FINANCING OF HEALTH CARE

As the moderator for this session stated in his opening to the audience, "If anything will change the American public's approach to the delivery of health care, it is the way that financing is developing and the way it is escalating..." This observation paved the way for one of the more substantive topics of the conference.The session began with a reaffirmation of the fact by Ms. Dorothy Orr, that the policymakers, legislators, and the Executive Administrator of this country must involve black experts at the corporate executive level in planning and policy formulation for health, and in other sectors of the American economy. Ms. Orr further stressed the need for black organizations and leaders to be in the forefront of lobbying for health legislation. She also noted that any health financing scheme to address the needs for black people be integrally related to the nature and prevalence of health and social problems in the black community. Ms. Orr strongly pointed out the lack of available private capital to finance health facility construction in the black community as a major deterrent to improving the long term health status of black people. The basic theme in Ms. Orr's presentation was that racism and economic deprivation needs to be remedied before an *effective* health financing program can be implemented in this country.

If the theoretical goal is "to provide universal access to quality health care for all people at a cost that they can afford or that the nation can afford," then we are talking about more than the financing of care, according to Ms. Ruth Hanft. She further stated that emphasis is really on a national health policy as well as a national health program. Ms. Hanft elaborated on this issue by pointing out that approximately 18 million people under the age of 65 have neither private health insurance nor resources to meet the costs of their health care. This group of 18 million people includes the poor who are ineligible for Medicaid, and the unemployed. Moreover, where the federally supported Medicare and Medicaid programs directed toward the poor, aged and disabled have reduced the accessibility problem, she believes significant differences based on race and geography still remain.

According to Dr. Peter Fox the differentials in Medicaid payments for whites and blacks (plus other non-whites) range from payments of $375 a year for whites to $213 a year for blacks and other non-whites – a $162 differential. The rationale for the dollar differentials in payments for Medicaid recipients by race is related to several complex issues. Dr. Fox listed three reasons for these differences: (1) difference in life expectancy; (2) blacks may disproportionately live in low-cost areas; and (3) provider discriminati[illegible]

In order to address some of the health care problems of blacks, Ms. Hanft presented the plan of action of DHEW. Some of these activities include: expansion of community health centers; restoration of funds to programs that were cut in the last federal administration; special emphasis on the assessment and the provision of primary care for poor children; re-emphasis on immunization for childhood diseases; and exploration of a program to restructure out-patient departments of inner city hospitals.

The interest of this session intensified as Dr. Sidney Wolfe disagreed with the previous speakers on financing. He stated that instead of talking about financing, we should think of "refinancing." Dr. Wolfe pointed out that the health care system has completely lost sight of the consumer, perhaps more so than any other element of the economy. "I say more so because the decision to purchase at an individual or collective level is far removed from the kind of purchasing decision that happens in a supermarket; it is displaced onto the provider," quoting Wolfe. In elaborating on his recommendation for a "refinancing" as opposed to a financing strategy, Wolfe provided an example of the impact of environmental disease on black people, stating that the government is spending the taxpayers' money disproportionately on treatment rather than on prevention. He also emphasized the need for strengthening the growth and development of HMO's as the best means of providing health care for blacks.

Finally, it was emphasized that blacks must take a leadership role to *refinance* and *redirect* the health care system – "a role," explained Wolfe, "as important or more important than the role blacks played in the Civil Rights Movement, which led to an articulation of the civil rights of a lot of other people."

Dr. Peter Fox identified three major problems with the health care financing system: (1) lack of universal access to financial as well as provider arrangements; (2) special limitations on services that the states mandate in their Medicaid programs; and (3) the created distortions in the health delivery system. In addition to reiterating similar issues by many speakers at the conference, Dr. Fox addressed some rather significant issues associated with health costs. In discussing the Medicaid program, Dr. Fox noted that physician reimbursement rates for primary care services are often quite low. This makes it difficult for persons on Medicaid to have access to physicians or, at least to the same kind of physicians that the middle class expects to visit.

The cause of rising health costs are many, according to Fox. He listed several: (1) rising insurance in an uncontrolled environment; (2) the increase in the number of physicians also in a non-controlled environment who are able to generate, to a degree, demand for their services; (3) rising incomes; and (4) increase in technology. Dr. Fox ended his presentation discussing how differential health status indicators of the U.S. black population *pay less* on behalf of blacks than on the behalf of whites.

The panel participants offered no concrete solutions to the problems discussed. Nevertheless, there appeared to be a consensus that some controls are needed in the health care system. After an agreement is reached on who should be controlled and by whom, the panel espoused that mechanisms be implemented and enforced. An acknowledgement of the need for more blacks on HSA's and other planning agencies was noted. The paucity of blacks in key administrative posts in DHEW was also acknowledged. Ms. Hanft requested that blacks interested in policy analysis apply to her office.

AUDIENCE QUESTIONS & ANSWERS FOR PANEL IV

DR. ALLISON: Lavonia Allison, from the North Carolina Health Manpower Development Program in Chapel Hill. I notice that each of the presenters this morning emphasized the need to have involvement from minorities at all levels of planning. In the HSA advisory board kind of involvement, there have been regulations sent down by the government, but many times the process by which people are approved to become members of those advisory boards is political. As a result, the people who are best qualified as advocates cannot be approved to get on those boards.

It also concerns me that, many times, the advisory board is a sort of rubber stamp for the professional people who do the planning and present the alternatives; there has been no mandate that those professionals who are employed by an HSA be more representative of the people they supposedly serve. So I was wondering; what can be done to assure that the people who are developing the plans represent the people for whom the plans are being made? A second question deals with the recognition that we don't have enough minority health professionals. In trying to attack that problem, we find it extremely difficult to get personnel statistics broken down by ethnic groups. I would hope that regulations could be developed that would assure that the demographic data are available for all types of health professionals.

DR. CORNELY: Ruth, would you like to respond to that?

MS. HANFT: I would like to talk, first, about the HSAs and the SHPDAs, the planning agencies in the local arena. It is, indeed, a real problem in getting knowledgeable and active representatives for the full spectrum of consumers of the community. We are currently working on amendments to the law. We will be working very closely with the congressional staffs. Senator Kennedy's staff is very much concerned about this, as well as Congressman Rogers' staff. The law has to be revised next spring, and it's one of our main considerations. Regarding the professional

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staffs of the HSAs, that is a real problem. It's a real problem for several reasons. First of all, the local communities recruit those staffs. They are not federal staff. How can we put in a set of guidelines about what kind of staff to recruit? I don't know the technique of doing that. I would very much like your suggestion and advice. One of the things I would like to suggest – and I've done this before other audiences – is that the organized consumers in the community really get active, go to meetings, get themselves known, lobby their city councils, lobby their Board of Supervisors. My concern is that the providers have so much staff backup from their own organizations. A hospital can put six of its personnel on something. The consumer doesn't have that kind of capability, and one of the things we've been thinking of is how to get consumers staffing for themselves so they can compete with the providers in the dialogue. One of the reasons we finally moved ahead on guidelines is our feeling that, if the federal government puts out some guidelines to help consumers particularly, they can begin to withstand the providers because they have the backing of these guidelines. I don't think it's a simple problem to solve, and I'd really like help. We are really breaking our heads on the issue of staffing, and on getting a good cross-section of consumers on those boards.

DR. WOLFE: We have one person spending almost full time on this problem. We've put a book out which may be of interest to you called *Trimming the Fat off Health Costs: A Consumer's Guide to Taking Over Health Planning.* It's essentially a cook book for consumer participation at a staff level, on the level of the advisory board. It's $2 and, if you write me at 2000 P St., I will send it out to you. But a big part of the problem is the "nominal consumer." Even when there is a requirement that a board have a certain percentage of consumers, the consumers often are hand-picked by providers. They make a joke out of consumer participation.

The second problem is the reasonably restrictive definition of a consumer in the law, which means that someone who really knows very much about health care, by definition, can't be a consumer representative. We have a number of people on our staff who are not health professionals but just because they work with us, they could not be consumer representatives on an HSA board. As far as developing a powerful and well-educated group to serve as a countervailing force against providers, one of the HSAs in southwestern Connecticut, I believe, has actually put in a budget item that says, "We will spend this amount to set up . . . ," and they have a completely consumer dominated group, made up only of consumer representatives, that spends money educating itself and acting as the already well-financed providers do, to try and present the other side of a number of issues. We think this should be a mandatory line item in the budget of every HSA, but with all the other expenses, it often becomes the bottom kind of priority.

But we have placed a lot of faith, because there isn't too much else going, in HSAs. Admittedly, the law isn't as strong as it could be. Amendments will, hopefully, make it stronger and regulations long overdue will, hopefully, make it stronger yet. But it's the only federally-funded consumer participation thing going in the country, as far as health is concerned. It's just going to have to work, because if it doesn't, we're going to be in really bad shape on a number of fronts.

Interestingly, one of the items that's included in the law (everyone thinks of HSAs as hospital beds and CAT scanners and things like that) is an environmental one; to consider those things in the local community that are having adverse health impacts on individuals. And if that were made a mandatory item in the budget, we would start seeing a much more important focus on prevention thanwe have.

MS. ORR: I would like to speak to the issue of the need for increasing the number of black professionals who are part of the planning and implementation processes of the delivery system. I have been struck with the fact that affirmative action and compliance review, for the most part, have been focused on industry, which is good. But I happen to think that government has gotten away without any kind of systemmatic review of what government agencies do. I think, therefore, that it's extremely important that there be pressure to make sure that there are legislative and administrative guidelines to require governmental agencies to establish affirmative action goals and that there be review outside the agency itself, as there is in the corporate world. We have someone who comes every six months to review our goals to make sure that we are moving in the right direction. Now, government simply hasn't done that, and that's perhaps where the solution may be. As black people, we are going to have to take the initiative in getting this done, particularly since it will be government that will establish the guidelines and the overall policy for what is going to happen. As long as we are excluded from that executive administrative level, I have the conviction that we will continue to have problems. But I do think there is a solution. Let's get on with affirmative action in the government.

DR. CORNELY: Let me just make one comment about that because I'd like to make it for the benefit of Ruth and Peter Fox, who are newcomers in the government and, therefore, this may not apply to them. That is, that HEW, particularly the health section, has a dreadful performance record in employing blacks of any background at the higher levels. I think that, if they're going to do anything out in the country and in the cities and in the states, if they're going to dictate something, they should start right in their own offices.

MS. HANFT: I agree. Could I make one comment about it? When I came into the Public Health Service, one of the first things I noticed was the absolute absence of minority people at all levels, including secretaries in the Office of the Assistant Secretary for Health. It was incredible. In *this city*; I couldn't believe it. I am currently in the process of actively recruiting for my own office. If you know any interested people with experience in policy analysis, please send them to me.

DR. ALLISON: That is the problem. You say "experience." Black people have not had an opportunity to get experience.

MS. HANFT: Anyone in this audience probably has the experience I'm looking for.

MR. HENRY: My name is Conrad Henry, and I represent First Harlem Securities Corporation in New York City. I have a question. I want to get back to health services financing. When the hospitals and the lobby which represents the hospitals in the AMA were in control, you had something called The Hill-Burton Act. A lot of money was spent under that program. Now I see a move toward having primary care delivered by Community Health Centers. My question is twofold. First, why are we talking about such small amounts of money? When Hill-Burton operated, we were talking about really serious money. Second, where is the tracer? We're talking about refinancing, redirecting funds. Where is the tracer to trace what is going to be done with Hill-Burton? Who is tracing that, and how do we know that Hill-Burton money will go to community health centers?

MS. HANFT: An amendment is being prepared for Title XVI of the Health Planning Act, which is what used to be the Hill-Burton Program. This change in law will redirect everything. There will be no new Hill-Burton construction money, except in inner city areas, for community health centers, and for modernization of inner city and underserved area facilities. No Hill-Burton money, if this provision passes, will go for the construction of general hospitals.

MR. STRETCHINGS: Frank Stretchings from New York City HSA. I have a question for Dr. Fox and Dr. Wolfe, particularly. One of the problems with the state plans is the existence of differentials between states. How do you see these being addressed in the national health insurance discussions and, as you are experienced with various alternative systems, what are your recommendations as to how to remove differentials between and among the states? Also, what do you think the future of consumer involvement in national health insurance should be, and how can we get there?

DR. FOX: I have to ask what we can do short of national health insurance and what is feasible only under some form of national health insurance or national health plan? Start with the more long-term picture first: Under a national health insurance scheme – and this is not addressing how the plan is financed or public versus private roles or any of those issues – one could start more forcefully than at present to redirect the funds into certain communities, such as through adjusting the payment levels to doctors so that the doctor in Manhattan or Montgomery County doesn't make three times for the same procedure as the doctor in rural Alabama, which is a problem right now. But that kind of shift is very difficult to do in the absence of national health insurance. Quite frankly, right now, we don't even have the data on how much physicians get paid. I mounted the first major study on this, starting about two years ago, and we're only starting to get some data in now. But we simply don't have the answers yet.

In the short run, I think the major efforts are likely to be through supply-side activities of the kind that Ruth has described, such as more forceful measures to reorient physicians who settle in Montgomery County. I think we've gone beyond the problem of solving the aggregate shortages of this country. If anything, many of us are worried about having too many doctors, and the consequence of that on health care expenditures could be a lot worse than the problem of having too many hospital beds. Many of us expect the percentage of GNP devoted to health care to rise from 8.6 percent to 12 or 15 percent almost regardless of what we do. So, I think there are things that can be done on the supply side, such as development of community health centers.

On the financing side, there are a number of things that we're looking at and we hope to take some action. Within the next few weeks, I hope we will have new legislation on Medicare/Medicaid payments to HMOs; we're also looking at the way in which Medicare and Medicaid finance new delivery systems, be they physician extenders or community health and mental health centers or other such facilities. So I think we can start to use the reimbursement dollar, even under the existing system, to tilt the system a little bit. But any more fundamental reform probably has to wait for national health insurance. Unfortunately, that wait may be a long time. Quite frankly, I see very little in the way of a constituency for national health insurance. To make the truth very blunt, you've got to ask who is for it. Well, the doctors aren't wild about it. The hospitals aren't wild about it. The insurance companies are "sort of" for it, but they're not going to spend a lot of effort on it. Then look at the people on the other side. I include the supporters of every single plan. They all have a favorite plan, and they've all got a choice they're willing to compromise to, and they all agree on that second choice. And that second choice amounts to nothing at all. So I have to ask, "Who is really willing to commit manpower and dollars to lobby for national health insurance?" Even though most people are in favor of the concept, I have to be somewhat pessimistic as to what will happen, and how soon.

Now making political predictions is a very dangerous business; I'd rather forecast the stockmarket. I hope I am going to be wrong, but I think one has to be concerned with how far away national health insurance is, and with taking intermediate steps short of national health insurance.

DR. WOLFE: I think I would agree with most of the goals of national health insurance, but many of them could be met by amendments to existing legislation, trimming $25 to $50 billion of fat from what we're spending now, and putting it where it needs to be put. Most of the plans for national health insurance are just financing mechanisms that don't really change what needs to be changed.

The second question that was asked of me was about the future of consumer involvement in HSAs. Well, we outline the details in this book *Trimming the Fat*, but just briefly in 20 seconds, consumers really have to control their HSAs in a very serious way. They have to get enough information so that they know for instance, that there is one hospital where they have a three times greater chance of dying after an operation. There is data on this right now, the names of the hospitals are kept secret. This is not a complete survey. The point is that our system goes from really good to really terrible, and the people who run it keep the really terrible names from being compared with the really good names. Consumer control means knowing the differences and trying to eliminate them. And until consumers know the differences, they will continue to have a generally apathetic attitude toward health planning.

MR. ISAACS: Walter Isaacs, Roxbury Dental Medical Group in Boston, Mass. Ms. Hanft spoke about dollars coming to hospitals, particularly out-patient departments, in terms of developing primary care capabilities. I am concerned with the large power base that hospitals have, and their ability to influence the distribution of health dollars. I am also, as the Director of a community health center, concerned with the issue of competition for those dollars. I wonder if you have any recommendations for dealing with that particular issue.

MS. HANFT: Okay. Let me explain what we are proposing in a little more detail. We are proposing a reform program for the out-patient departments of about 20 inner city hospitals in the first year. The program will operate under very strict guidelines supervised by consumer boards, separate from the regular hospital boards with separate sets of accounts so the money doesn't get mixed up in the general hospital funding. We are also proposing, in about 10 hospitals a year, to try what is being done in Contracosta County in California. This is a variation on the HMO concept for an enrolled population in an underserved area, using an existing facility, a county hospital, as the base, with again, a consumer board. And finally, the largest part of the proposal is a vast expansion of community health centers, particularly in the inner cities. The dominant part of the proposal, in both dollars and numbers of service centers to be established, is the community health center expansion program.

But in a number of areas the hospitals are already there; they are serving a large number of people, but serving them inappropriately. What we want to do is to take a hospital that is willing to develop a program of primary care with a consumer board and a separate set of accounts, and put in full-time physicians so families can see the same physicians every time they come in – not house staff, not residents or interns – but fully salaried physicians. They would get comprehensive primary care, continuity of care, and all arrangements made when they need secondary care. They would not be ping-ponged around the system. That's what we're trying to do there.

DR. SMITH: Edgar Smith, health policy fellow at the Institute of Medicine. The speakers have alluded very briefly to the question of prevention. Ruth, I've heard you indicate this as a major concern of the current Administration. I wonder if you could articulate or express to this audience some of the specifics that this Administration plans to accomplish in the area of prevention.

MS. HANFT: The first one is the major immunization drive recently announced, which seeks to reach 90 percent of the children in the United States over the next several years. Our immunization rates are a catastrophe. We are getting measles cases when we shouldn't get measles. There could be an outbreak of polio. There are at least three prevention task forces working right now in HEW. One is working on a major nutrition program and another on a smoking program. There is also a general prevention task force that is trying to develop an overall strategy for prevention.

The child health program that I am personally working on, the maternal and child health program, has a very heavy dose of prevention in its specifications. Finally, in working on national health insurance benefits –and I don't know whether I quite agree with Peter – we are looking at Lester Breslow's lifetime health monitoring program as a possibility for part of the benefits in a national health insurance program. As you know, that is a very prevention-oriented package which, by age group, specifies what types of services should be provided for prevention. There is also the drug reduction task force that I chair, that's looking across all the drug abuse programs of the department, not merely heroin. It's looking at the overuse of barbiturates, psychotrophic drugs, all kinds of things, and is making a major effort to look at all those programs and make them more effective.

DR. CORNELY: Thank you very much. Let me thank the Panel for their very excellent presentations, and I would like to thank the audience also for their questions and thoughtful statements.

PLENARY SESSION IV

TEXT OF PANEL PRESENTATIONS

PROBLEMS & ISSUES IN THE FINANCING OF HEALTH CARE

DR. CORNELY: Our schedule for today will run well into the afternoon, all the way until 5:00 o'clock, with just a bit of time for lunch, when we will have a speaker in the person of Therman Evans. Therefore, we would like to get started pretty quickly. We would like to establish certain ground rules. Because of time limitations, we would like to ask that statements from the audience be restricted to questions. If there are any comments to be made, please make those comments as succinct as possible; people are much more attentive when comments are brief and to the point. This panel is one of the most important of the conference; issues of finance in health care are at the center of the problem. If anything will change the American public's approach to the delivery of health care, it is the way costs are escalating. At the present time, as previous speakers have pointed out, health care consumes 8.5 percent of the gross national product, 140 billion dollars. I would suggest that when we're talking about these numbers, we're talking about medical care almost exclusively. We do not include much prevention or education in that 140 billion. The members of this Panel are distinguished and well-known individuals. I'm not going to take any of your time to try to give lengthy introductions because you know them well. They have established reputations, and they are seen on television and in the press. The first speaker will be Mrs. Dorothy Orr, Vice Presdent for Corporate Social Responsibility with the Equitable Life Assurance Society; second, Mrs. Ruth Hanft, who is Deputy Assistant Secretary for Health Policy Research and Statistics of the Department of Health, Education and Welfare. The third, who is seen much more often on television than some of the stars of the medium, is Sidney Wolfe, Consumer Advocate. The last speaker, who will "anchor" the panel, is Peter Fox, Acting Assistant Administrator of the Health Care Financing Administration, affectionately known as "HICFA". Dorothy, would you start please?

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■ *Dorothy Orr, Equitable Life Assurance Society*

MS. ORR: It is, indeed, my pleasure and privilege to join you in this very important conference on Health Care Policy and Planning for blacks. I know of no other issue confronting black people today which is more critical, more urgent and more basic to our success in the struggle for equity and equality of opportunity. For without good health and access to adequate health care, the ultimate achievement of full employment, of minority-owned businesses, of adequate housing and education, will be futile – yes, even a deterrent to the realization of Martin Luther King's dream.

It is appropriate, even visionary that Expand Associates should sponsor a conference which emphasizes health policy and planning for black people. I have a deep conviction, as I know many of you do, that one of the underlying issues impacting on the overall progress of black people in our country today is a lack of participation at the policy making and financial planning levels of most large organizations. This is so in the area of health care, welfare reform, development of economic strategy, and corporate long-range financial planning. It applies to all institutions, governmental, industrial and labor. The strategy that will best assure that black interests will be attended to and translated into policy planning, is for black experts to *be there* in corporate executive suites, in the President's Cabinet, in the planning and policy levels of those governmental agencies which are developing guidelines and standards.

Black organizations and leaders must be in the forefront of lobbying for health legislation which recognizes the special needs of blacks. They must support black representatives on Congressional committees which hammer out legislation dealing with the financing of plans for health care, for welfare reform, for minority business, and for full employment. The thrust of the '60s was the articulation and dramatization of the problems and issues confronting black people in this country. The challenge of the '70s is the involvement of black people in the conceptualization and planning process, which will change the health care systems to be responsive to the need for adequate health care for all people, including blacks and the poor.

When I served as Commissioner in the early '70s with the New York State Commission on Human Rights, I was struck by the tremendous push for affirmative action plans relating to entry level and lower management level jobs in industry and government agencies. I was equally struck by an absence of goals and timetables for officials and managers in upper management positions, where the most important decisions are made in the areas of policy formulation and organizational planning. At the Equitable, we strive to come right with all people. There is equal attention, therefore, to the need for minority officers to handle our investments, our insurance, our business planning and management. So I think this conference, by its very topic and thrust, relates to one of the basic issues essential to the financing of health care and its delivery to blacks; namely, the need for black leaders to be involved in the planning and development of strategies, at the highest level, which will make adequate health care available to black people. This participation must include memberships on health care planning councils across the country, as well as positions in government health agencies and private industry. The topics of the conference underscore the urgent need for our involvement as black people, if policy formulation and health planning in our country is to be effective. All of us in this audience should be profoundly concerned about the continuing absence and minimal numbers of blacks at health policy making levels. We should also establish as a major priority the need for strategy to increase the number of blacks in health planning, as we develop a concurrent strategy for evolving a health care delivery system and its financing. We need health planners who are knowledgeable about the issues and about the barriers to an adequate health care system. We need strategists, health strategists, who understand power, who understand politics and the art of tradeoffs, and who are capable and committed to developing a health delivery system which takes into account the needs of all people from all socio-economic groups.

As I pore through the literature, including health journals, news articles, the pronouncements of politicians, of legislators, of insurance companies and of poor people, I am unable to find any individual or organization that does not believe adequate health care to be a right of every American. What's more, I think that most Americans, who are usually rather proud of our reputation as being first in everything, are both alarmed and ashamed that the United States ranks 18th in the world in male life expectancy, 11th in female life expectancy and 13th in infant mortality. As blacks, we are equally concerned with the statistical data which reveals that infant mortality rates for non-whites are double that of whites, and that non-white workers are reported to have more disability days than whites. The findings from the Congressional Budget Office confirm what is already known, that non-whites have poorer health and less health care than whites and a 50 percent higher level of disability, and that health care for blacks tends to be crisis-oriented rather than preventive. We know that health care and hospital facilities, as well as ambulatory and home health care services are not sufficiently available in ghetto neighborhoods. The majority of all Americans revealed in a poll recently that they saw the crisis of health care delivery as one of the most serious in our country. Therefore, I propose to you today that the issue is not a lack of knowledge of the existence or nature of health care problems, neither is it a lack of technology. I also would venture to say, although I am sure that some of you would disagree, that the issue of inadequate health care funding is not a reflection of lack of commitment of America to solution of the crisis; rather, I believe it is one of how to finance an adequate health care delivery system for all people – the poor, the middle class, the employed and the unemployable – while maintaining the free enterprise system in a capitalistic society.

An examination of the various health care bills and their plans for financing reflect a range of solutions, which basically include, on one hand, government financing and management, and, on the other hand, individual or private financing of health care. What appears to be the barrier to the passage of legislation for adequate health care is related, I believe, to a fundamental philosophical question. It is an issue which is of concern to both the public and private industry alike; namely, the trend toward a bigger and more powerful government, accompanied by decreasing opportunity for free enterprise and full employment as the operating principles of our democracy. My own experience with social programs and governmental regulation indicates that governmental financing and government-supported employment are not the answers to our social problems. It is true, however, that a degree of governmental regulation, as well as some mechanism of accountability for all institutions and systems, is necessary. I firmly believe, however, that the substitution of government action for private initiative is contrary to the free enterprise system, is inimical to democracy, provides only temporary relief, and becomes economically overwhelming to the taxpayer. The trend toward more government control and involvement is no more than a reflection of a failure of the major non-governmental institutions in our society to take seriously the need for them to participate in the solution of social problems through comprehensive planning.

With regard to health care delivery financing, I wonder if the more basic question is not related to the high rate of unemployment, particularly for blacks; inflation and an adequate education system which produce people with no training and no jobs to generate the income necessary to purchase the health insurance they want and need.

Is it not a matter of economic and monetary policy that private capital is not available for the building of health care facilities, serviced by qualified health care personnel in ghetto communities? Is it not an issue of racism and economics that black families have insufficient income to afford medical school training? Is it not discrimination that medical schools continue to accept limited numbers of black students, the Bakke case not withstanding; a factor which then results in insufficient numbers of black doctors to service residents of ghetto and rural areas? Is it not an issue of prejudice that black contractors and architects from ghetto communities do not receive contracts or sub-contracts to build facilities, even in their own communities, a result which also impacts on the availability of jobs for ghetto residents who, because of their joblessness, are unable to finance their health care?

The problem of health care and its financing is not one which is isolated from these issues. It is a problem which is the result of a lack of responsiveness and responsibility on the part of institutions other than government to do what is right in making the free enterprise system work on behalf of all people, irrespective of race. The fundamental issue of financing of adequate health care for black people, for any people, will not and cannot be solved without the totality of society – government, the public, industry –coalescing to find the methods to end discrimination, to develop an economic policy which copes with inflation, and to establish comprehensive economic plans which will make available meaningful work with adequate compensation for all people who are employable. As long as there are large numbers of poor people, black or white, who experience discrimination and who do not have access to adequate education with an emphasis on employment and jobs, the financing of health care will remain a major problem and barrier to our achieving an adequate national health care system. The implications of large numbers of poor, unemployed people who do not have the economic means to provide for health care is that the government must provide the money to cover health care costs which moves our country to more and bigger governmental involvement.

The health industry is a billion-dollar industry and the third largest industry in our country. Therefore, it is powerful. The direction it takes will be critical to how the capitalistic system goes in this country. The basic issue, therefore, is related to who will direct that industry and who will manage it; government, or individuals and other institutions of our society. If we continue to believe in democracy, capitalism and free enterprise, the issue then is how to make that system work on behalf of poor people and black people. The basic problems with health care for blacks are racial and economic, resulting from the fact, affirmative action notwithstanding, that large numbers of blacks are excluded from access to union jobs, to employment and management in the professions, and are therefore, unemployed.

Excluded from access to the free enterprise system, they are unable to buy health insurance. There is an interdependency and interlocking of problems in the search for solutions to societal problems, including the problem of health care. This interdependence of problems requires comprehensiveness in health planning, taking into account an educational system which prepares people for the kinds of jobs which will be available for the rest of the century, a human-powered economic system, and all of the other systems that I think you know about, including the system of corporations who must have available to them capital required for expansion and job creation. While health planners and advocates must concentrate on health delivery and financing strategy to provide blacks with quality health care, they simultaneously must interface with educators, economists, legislators, physicians and industry, who tend to act out of vested interest and in isolation. The solution to the health care financing issue is full employment and economic growth providing profits for industry and jobs for the citizens of this country; it is the freedom of choice of health plans and insurance for which people who are employed can pay. I think the solution is a system which recognizes the need for subsidy to black men and women who cannot pay the costs of medical education, and provides that subsidy. It is a kind of *gestalt* which recognizes the need for financing of research, and for black scientists to search for cures for such afflictions as Sickle Cell Anemia. It is industry and unions who find ways to provide employment for whites and blacks. It is government which is an enabler, which supports, without taking over, the role of industry and people and all of the institutions which constitute our society.

Finally, the solution is a society- government, unions, industry and people- who are humane and who share in the provision of financing for health care for people who are ill and unemployed.

As a social planner who has had experience with social programs sponsored by both government and private industry, I have tried to share with you a description of the totality of social issues which should be considered in any plan for the financing of health care. As you can see, I have not presumed to undertake a description of the specifics of the financing of a health care delivery system for blacks or for all people; you are the experts at that task. But it is my hope that these principles will serve both to guide and inspire you, the health experts, to collaborate with the experts of other systems, so that there will be a comprehensive approach to the solution of critical social problems confronting society. It may be that some of these principles are idealistic and unachieveable. I have a conviction, however, that on a long-range basis all of us from government, industry and private organizations must try to work collaboratively on the solution. In the meantime, I must say that, if we cannot achieve the goal of an interlocking and comprehensive solution to our social problems, including health care, through planned change in the systems which are critical to the survival of free enterprise, then we must turn to the institution of last resort -- government to provide adequate and comprehensive health care for all people. Thank you very much.

■ *Ruth Hanft, Office of Assistant Secretary for Health/DHEW*

MS. HANFT: Before I start, Mrs. Orr mentioned the Congressional Budget Office volume. I think you should all have it. It is very revealing as to what happens when we rely on financing programs alone.

It's called *Health Differentials Between White and Non-White Americans*, and you can get this either from the Congressional Budget Office or from the Government Printing Office, and it's a very worthwhile document. It documents much that we have known and puts much previously scattered data in one place. I think we all share the same goal, and that's the goal of providing universal access to quality health care for all people at a cost they can afford or that the nation can afford. And when I say "universal access to quality care," I don't merely mean the financing of care. If we pay for care, yet there are no resources to provide that care in the inner cities and in rural areas, then there is no care, even though the dollars are there. So in talking about national health insurance and universal health care, we are not talking insurance; we're really talking national health policy and a national health program. While there have been remarkable strides made in improving the health status of black and other minority populations over the past 20 years, much still remains to be accomplished.

The most conspicuous problem for many low-income people, approximately 18 million people under the age of 65, is that they have neither private insurance nor other resources to meet the costs of health care. These are the poor who are ineligible for Medicaid, the unemployed, the under-employed, the very people who often require the most health care and receive the least. Many other people, although they have some financial coverage, have inadequate coverage; they may be covered for hospital care, but not for physician visits, preventive services, home health services, or long-term care services. Most such services are very inadequately covered for a majority of the population.

Federally-supported health care financing programs such as Medicare and Medicaid, aimed at the poor, the disabled and the aged, have narrowed the access gap. But differences in use by race and geography remain, and they are substantial. The poor and underserved still have to rely primarily on clinics, out-patient departments of hospitals, and emergency rooms for their health care. People in rural areas have inadequate health care resources, and they don't even have out-patient departments and emergency rooms in many instances.

While infant mortality rates have steadily declined over the past decade, and the rate of decline has been somewhat larger for blacks, infant mortality is still 85 percent higher for black than for white infants. Life expectancy for all of us is too short, but it is six years shorter for black people than for white people. Problems of access are, in part, the result of insufficient financing, but they are also the result of other factors – the environment to attract health professionals, a community's willingness to work at getting services into the area, and the way we pay for our health care services – that favor high-priced services and discourage professionals from working in inner cities and rural areas. Compounding the problems of maldistribution of services are the proliferation of some resources, and skyrocketing costs. Health care expenditures are increasing by 15 percent every year. They are estimated to have reached 160 billion in Fiscal Year 1977, and could easily exceed 200 billion by 1979. States, as a result, and the Federal Government, in the last administration, cut back on many of their programs, particularly the Medicaid program and the Community Health Centers programs, which affect low-income and minority groups most strongly. Cities are increasingly burdened with caring for low-income people not covered by other public programs or third-party payments, and I needn't tell anyone here about the crisis in the New York City Health and Hospital Corporation or the crisis in the Los Angeles County and the California County Hospital Systems.

The magnitude of the continuing urban health problem is attested to by the fact that over 5,000 of the 25,000 census tracts in urban counties are medically underserved. These are densely-populated areas, frequently with as many as 15,000 people per tract, and with heavy concentrations of low-income and minority people. The urban poor utilize the hospital emergency room and out-patient departments for primary care, although these facilities are ill-equipped and inappropriately structured to provide adequate or continuous care. In fact, one-third of all out-patient visits by the minority poor are to the emergency room or the out-patient department, well above the 10 percent level for all other Americans. This is largely due to the lack of availability of private physicians and the unwillingness of many physicians to serve low-income people.

Well, what are we going to do about it? As we move toward reforming the system, the Public Health Service sees our responsibility as one of working to get the most out of each health care dollar spent, rather than reducing programs. In fact, we are proposing the expansion, once again, of primary care centers. We are moving rapidly to expand community health centers as OMB frees up funds for us. We believe now that cost containment objectives can be achieved without compromising the other equally important objectives of quality and access to care. In fact, we believe that cost containment can free up funds to move more heavily into the areas of primary care, into the preventive services and away from the high-cost tertiary care services that are in excess in many parts of the country. We are seeking to restore cuts to programs made by the last administration which affect vulnerable persons, the poor, the disadvantaged, the elderly, children and the handicapped. We are working toward these goals in several directions. There are now in place a number of provisions that can help us with the problem of inflation. These include the PSRO, Health Planning and Certificate of Need programs, as well as the proposed Hospital Cost Containment Bill. Recently, we released the first quantitative guidelines for health planning; we hope these rules will halt the increase of unneeded beds and the proliferation of expensive equipment. The proposed CHAP Program would place special emphasis on health assessment and primary care for poor children. This is coupled with a new emphasis on immunization. We expect, by 1980, to have 90 percent of all the children in this nation immunized for all the basic childhood diseases. We are also currently – and my office is doing this – reevaluating all service programs for children and mothers, and we are seeking to create a comprehensive maternal and child health approach within the next year or two, hopefully to be able to reach every child in this country. A child has childhood but once and, if we lose the potential for the child's development, that loss is lifelong. Dr. Richmond, in particular, is gravely concerned about the status of the health and the development of children in this country.

In still another area, we are exploring programs to restructure the out-patient departments of inner city hospitals, to convert some of these out-patient departments into truly comprehensive family-oriented primary care facilities. We are proposing to expand the community health centers, and we are also proposing to try to set up some demonstrations in enrolling populations in comprehensive health care settings, based out of the smaller county hospitals. Finally, in our consideration of a national health program, we will also be working to restructure the system to have it more rational and efficient, and to provide genuine access to quality care, not merely financing of care. Thank you very much.

Sidney Wolfe, M.D., Consumer Advocates

DR. WOLFE: If one has to pick out a single statement of the problem of the health care system – and this is not original to me, but it needs to be repeated often – it is that too many people are making too much money. Therefore instead of talking about financing – simply adding more money to an already bloated, constipated system – I think the phrase "refinancing" is the much more appropriate one. Ruth Hanft has just implied in a number of ways that the government's current trend is toward pulling money from one thing and putting it into other things that have a much better return for consumers, instead of a much better return for producers. I think that the operational corollary of too many people making too much money off the health care system is that it is a system that has totally lost sight of the consumer, the people who are supposedly being served by it. Perhaps much more so than any other section of the economy, health care is producer-dominated. I say "more so" because the decision to purchase at an individual or collective level is far removed from the kind of purchasing decision that happens in a supermarket; namely, it is displaced onto the provider. So I think the word "refinancing" has to be the subject of any serious discussion of what we're going to do. We can't keep going up from 8½ percent of the gross national product, as Paul mentioned, to 9 or 10, *ad infinitum.* Whether it's going to crack, or crumble, or have a crisis, or whatever phrase is popular these days, it isn't going to work out at all. And those for whom it is working out least well are poor people, black people, whose health indices are already bad, and although getting somewhat better, are nowhere near what were hoped 10 years ago when Medicaid, which is basically, a financing, instead of a refinancing mechanism, was put into place. Pouring more money into things as they are can't work, and won't work; it just fuels the fires of inflation and promotes the domination of the system by producers.

I think that one could say conservatively that somewhere between $25 and $50 billion of our health bill (which is now $160 billion) is pure unadulterated waste from a consumer standpoint; this is extra profit, largely corporate, but flowing also to the pockets of the individual practitioner. So what can be done if we are really going to refinance the system and put something other than a checkwriting mechanism in control of it? I would just like to touch briefly over four areas where refinancing is very important and where it is particularly important to black people. Prevention is like apple pie and fatherhood. Fatherhood used to be called "motherhood" before liberation. But, when one looks at some of the recent data, prevention is much more of a problem and much more important for black people than for anyone else. We now are told and have to believe that cancer is basically an environmental disease which is preventable, caused by smoking, occupational exposure and so forth. Blacks are hit hardest by most kinds of cancer, and occupational exposures are one very important reason for that. I've recently been looking at some data showing that pesticide levels in the fatty tissue of people who were sampled during surgery are higher in many cases in black people. So a number of environmental factors that cause cancer impact more heavily on black people. Yet the government's approach to preventing this disease is a farce. Most of the money is being poured into treatment; not that people who've already been exposed 30 years ago and who are now getting cancer shouldn't be treated, but the allocation of funds is quite disproportionate.

Recently, I suggested to the National Cancer Institute that they take a look at those chemicals that are already clearly, unequivocally shown to cause cancer yet are totally unregulated by the government. A couple of examples I mentioned were chromium and nickel. Chromium has been known for 30 years to cause lung cancer in humans; it has not yet been regulated by the Department of Labor as a work place carcinogen. And I suggested that the National Cancer Institute, instead of serving as a banking operation for people who are treating cancer, should be criticizing its fellow government agencies for not regulating for the prevention of cancer.

Another area where refinancing or redirection of effort I think is very important, as far as improving health care in general, black health care in particular, has to do with something called the delivery mechanism. I agree that this Congressional Budget Office study is very good in terms of showing that financing isn't enough, but it really – perhaps because of its brevity – doesn't have time to deal with such topics as health maintenance organizations. I picked the topic of HMO's because it is a type of a decentralized control mechanism, as opposed to reliance on Washington to take care of things. The data, consistently, with the exception of certain profit-making HMO's in Southern California, show that HMO's are a much better way to deliver health care. They keep people out of the hospital who don't need to be there; they keep people from getting operations they don't need; they focus on prevention rather than treatment; and, they save money. There was a study recently done here in Washington, showing that within a population of poor black people, those who were taken care of in an HMO, Group Health Association, were able to be taken care of for 25 percent less than those who were in the fee-for-service system. Yet, in this very city, the Department of Health has admitted that they have largely failed to even alert poor people to the fact that they have a better option.

There are a number of reasons why HMO's haven't flourished in this country; one of them is that most of them don't own their own hospitals, and have had to buy in at almost unaffordable rates. So many of them that don't own their own hospitals are in severe financial trouble for that reason. A second reason is that HMO's are extremely threatening to the so-called private sector, fee-for-service, kind of medicine. In Boston, for instance, one of the HMO's which is now up to 70 or 80,000 members – and doesn't want to build hospital beds because, as everywhere else in the country, there are too many hospital beds – is trying to negotiate with outlying community hospitals that are overbedded and underoccupied to admit patients to these hospitals. And the hospitals are delighted. The ones who aren't delighted are the private practitioners in these areas, who see HMO's as a threat to fee-for-service medicine, which it is, because it takes care of people for less. As HMO physicians, they might have to survive off of an income of only $40 or $50,000 a year, instead of $80 or $100 or $120 or $140,000 in the private fee-for-service sector. Another reason why there is great resistance to HMO development – particularly HMO development for poor black people – is that it is a diversion of a clinic population away from the high technology, medical education center, which depends heavily on poor people for so-called "teaching material." When people are diverted from that kind of center into an HMO, even though they are getting better and less costly care, there is resistance. It need not be said that these institutions have a great deal of influence. There needs to be a major emphasis on HMO's to make HMO's much more known to poor people, particularly black people, and to divert people from these wasteful, more expensive and, I think, more dangerous components of the health care system, where the poor are now and have traditionally been going.

The third topic under this refinancing/redirecting has to do with manpower and womanpower. It is interesting how the effort, several years ago, to make mandatory a couple of years in the service of one's country as a physician, since the major portion of a physician's training is paid for now by the government, was resisted most strenously by medical students. They preferred having it be optional, which it is now. Although the National Health Service Corps has expanded beyond what it was several years ago, and will at least provide more physicians in underserved areas, I personally don't believe that the maldistribution problem is going to be solved in any way other than by mandatory service to one's country, since one's country is already paying most of the medical education bill. The group that is least likely to resist national service is black health professionals. The way the system operates now, if you're poor, you can have the government pick up your tuition. Then you get a chance to serve your country. This is obviously a discriminatory system that falls most heavily on black physicians and other black health professionals because they come from financially disadvantaged backgrounds and are more likely to have to depend on that system. Since blacks are already participating in this system, I think that there should be much more lobbying to make it mandatory for everybody. That is not to say that the health problems of underserved areas should only be served by people with a two-year commitment. But when more people receive an exposure to the problems of underserved areas, the more they will decide to stay; there are many things very attractive about serving in rural areas and other such places in this country.

The last area which Ruth Hanft has alluded to is so-called health planning. "So-called," I say, because I think that up until now there has not been any such thing as health planning. There has been something called "health planning" and a lot of money has been spent and a lot of people have jobs called "health planning" but from the consumer standpoint, planning is nonexistent. It has been totally provider planning to build more hospitals and buy more CAT scanners. And unless health planning turns in the direction of decreasing, rather than supporting high technology medicine and decreasing the number of beds rather than increasing the number of beds, it isn't really planning for anything other than allowing providers to make more money. The inclusion on a mandatory basis of minority representation in the planning board has got to happen, although there has been a setback in the courts on that. I think, lastly and just by way of summary, we have gone through a couple of phases of "control" in the health care system. It was originally in private hands, largely providers. The health professions were allowed to regulate themselves. The hospitals were allowed to regulate themselves. We are now in a so-called governmental phase which, in many ways, is just a replication of the first phase; the government, in exercising its so-called regulatory power over providers, has instead been dominated totally by providers, so that it's just spending more money through tax dollars to allow the same group of people to control things. I hope that we are moving out of that, not saying that there isn't a major role for the government to play. But some of the things the government is doing now can lead to a third phase, the consumer-dominated phase. Whether it is health planning in which consumers are in the majority on the health planning board or whether it's the HMO concept where consumers have much more of a say as to how the HMO is run, we have to move into a phase of consumer domination; nothing else will work. The role of blacks in taking a leadership to refinance and redirect the health care system is going to be as important or more important than the role played by blacks in civil rights, which led to an articulation of the civil rights of a lot of other people. And, so, I am much more comfortable working with you than I am with other people in the health care system. Thank you for inviting me, and I look forward to continuing to work with you.

■ *Peter Fox, Ph.D., Health Care Financing Administration/DHEW*

DR. FOX: I am with the newly-created Health Care Financing Administration, which brings together three programs of the Department of Health, Education and Welfare. The first is the Medicare Program for the aged and disabled. The second is the Medicaid Program, a joint state-federal program, for persons related to various welfare categories. And the third is the various quality assurance efforts of the Department, in particular the Professional Standards Review Organization Program and various programs to establish standards in hospitals, nursing homes, laboratories, and other provider institutions. The budget of the Health Care Financing Administration is a big one, and not necessarily a very efficiently disbursed one. The Medicare budget this year is estimated to be $25 billion, the Medicaid budget $11 billion, matched by another $9 billion in state payments.

The major problems, as I see them, with the health care financing system are at least threefold: first, is the lack of universal access both to financial resources and the services of providers. Medicare provides nearly universal coverage for the aged. But of the non-aged, roughly 10 percent of that population, do not have any coverage at all and another 10 or 20 percent have exceedingly poor coverage. Private coverage often provides a very narrow range of benefits, concentrating, as Ruth said, on acute hospital services only, although the picture here has been changing for a number of years. Medicare, to a degree, mirrors private coverage and concentrates on acute hospital services, plus physician services. The most notable exclusion from Medicare are out-patient drugs. The Medicaid benefit package, in contrast, is extremely comprehensive on paper, although there are significant variations among the states. Included among the problems of access are some which people are not much aware of. One is that physician reimbursement rates, particularly for primary care services, are often quite low, making it difficult for persons on Medicaid to have access to physicians or, at least, to the same kind of physicians that the middle class expects to visit. Another access problem results from special limitations on services, such as 10 doctor visits a year or 30 days of hospitalization, that are mandated within individual state plans.

The second major problem is the rising cost of health care. Medical costs have been expanding at a rate of roughly 50 percent over the consumer price index year after year, except during three very brief years, '71 to '74, when they were under special controls. The hospital sector is the most inflationary, increasing as it is at twice the rate of the consumer price index, and there is no reason to believe that health status is increasing commensurately. The causes of rising health care costs are many, and I will mention some of them; rising insurance in an uncontrolled environment; increased numbers of physicians, who are able to generate demand for their services; rising incomes; and new technology. The first two factors are, by far, the most critical.

The third major problem with the financing system is the distortion in the delivery system that is created by the other two. The emphasis on hospital reimbursement goes right along with the rising cost of hospital services. In addition, Medicare, and to a much lesser degree Medicaid and private health insurance, have exacerbated prevailing fee patterns which pay more for identical services in resource-rich areas than they do in resource-poor areas. There has also been the failure to reimburse for certain kinds of delivery mechanisms, such as prepaid group practices or HMOs, and certain kinds of manpower, such as physician extenders outside institutional settings.

The health status differentials affecting minorities are well known to this audience, and I think I will simply omit them because they have been talked about previously. With regard to the use of health services, the differential remains, but I think it is important to recognize that there has been some improvement, some significant improvement, although it's not good enough. If one looks at physician visit rates, for example, 15 years ago, there was roughly a 50 percent differential. Today, there is roughly a 10 percent differential. That is a very significant change. Now, if it were a 10 percent differential against a population having equal health status, I would say, "Relax; with a 10 percent differential, I, personally, wouldn't get too excited about it." But we all know that the health of the black community is a good deal worse, and we need to do better.

Mirroring the general problems in health care financing, the programs of my agency pay less on behalf of blacks than they do on behalf of whites. For hospital services, the admission rate is roughly 15 percent lower for blacks than it is for whites. Now if you believe this is excess hospitalization, that may not be all bad; nonetheless, the length of stay for non-whites is about 20 percent longer, reflecting the health status differential. For physician services, the percent of the white population that exceeds the deductibles is 53 percent. So 53 percent of whites receive some payments under our Part B program, which is the physician program. The percent for non-whites is 40 percent. For

Medicaid, again, the same kinds of statistics: for non-whites, Medicaid payments amount to $213 a year; for whites, $375 a year.

Now, the reasons for these differentials are complex, but I think one shouldn't exaggerate these complexities. Let me just list a few. First is the difference in life expectancy alluded to earlier; second, blacks disproportionately live in low-income areas, third is provider discrimination. I should make a point here – it's one that Bob Ball, the previous and very respected Commissioner of Social Security makes – that the Medicare program went a long way toward desegregating hospitals in this country, simply by refusing to pay for care in segregated hospitals. Through an interpretation of the law, the discrimination provisions in federal legislation have been judged not to reach independent practitioners, but Medicare has used civil rights legislation as a major tool for desegregating hospitals. Another factor is that the Medicaid benefits tend to be the most restrictive in the southern states, where a disproportionate number of blacks live. There may also be cultural differences that enter into it. For example, it has been written up in the literature that blacks are less willing to put the elderly into nursing homes than are whites. I have not seen good documentation on this. I'm not saying it doesn't exist, but cultural differences may make a difference. Finally, the shortage of providers, which Ruth mentioned earlier, has a major impact. These are bleak truths. I don't have any easy solutions to offer. As I mentioned earlier, we are a new agency; I, personally, am new to the job.

One of our major efforts is to look at ways in which the reimbursement system can be changed to provide some leverage, to counteract some of the perversities of the existing system. I would say, in way of a concluding comment, that the problems are exceedingly complex; that's not an excuse for inaction, but to come up with simple palliatives means that one doesn't understand the problems. Thank you very much.

DR. CORNELY: Well, let me thank the Panel members for their rather succinct presentations. I think that these have been excellent presentations – thought provoking, challenging, and stimulating.

CONFERENCE ADDRESSES

DINNER

Friday – October 28, 1977

Roy Schneider, M.D.
Commissioner of Health
U.S. Virgin Islands

LUNCHEON

Saturday – October 29, 1977

Therman Evans, M.D.

Operation PUSH

(People United to Save Humanity)

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HEALTH PLANNING FOR MINORITY/BLACKS IN AMERICA

ROY SCHNEIDER, M.D.
Commissioner of Health, U.S. Virgin Islands

Mr. Master of ceremonies, distinguished guests at the head table, friends, ladies and gentlemen. I am truly honored and priviledged to have been asked to share this evening with you, and for the opportunity to present you with my perspective on health planning as it relates to blacks in america. Many of these ideas have evolved from my broad responsibilities for the health of all the citizens of the territory of the U.S. Virgin Islands – as the Commissioner of Health.

This meeting on planning for the health of blacks in the U.S. is a most timely one. It is widely accepted that solutions to the chronic health problems in America are long overdue. And there are a variety of proposals from several camps to combat this crisis. While our citizens are confronting us with a plea to meet their health needs now, politicians and government leaders espouse cost containment and immediate reductions in health expenditures. The nation is in a health crisis – a crisis marked by runaway costs and greater expectations of the people.The significance of a meeting such as this is in providing a common ground from which to communicate, to plan, and to act with broader vision on terms of mutual interest and concern to us all.

This evening, I will present for your consideration some approaches to looking for solutions to the chronic problems of providing acceptable, accessible, equitable, quality medical care to minority groups. Before one can address plausible solutions, an overview and scope of the health system in the U.S. and its implications for blacks should be considered. Moreover, contributing factors to health such as socio-economic status, cultural differences, political structures, geographic variations and manpower availability must also be taken into account in formulating meaningful health plans. Even though the following indicators are familiar to all of you as health professionals, let me begin by briefly documenting the health status of the black and poor so as to place our plight as a people in perspective:

- Infant mortality rates have shown a steady decline of 4% per year since the mid-1960's, to a figure of 16.1 deaths per 1000 live births. High infant mortality in families with low income and poor education of parents parallels the high infant mortality among non-whites. Infant mortality for non-whites has remained 2/3 higher than for whites.

- Life expectancy for both men and women has been improving in the U.S., though unevenly among various groups of the population and with considerable discrepancy in mortality between whites and other racial groups.

- There is substantially more disability in lower income groups than in higher income groups; men in families with less than $3,000 income have about twice the amount of disability, restricted activity and work loss as do families with more than $7,000 per annum.

- Low-birth-weight infants are most common among teenage mothers and those who did not receive any pre-natal care.

- Black children less than 4 years of age have a polio immunization rate 1/3 lower than white children.

- The costs for health care in America are spiraling, eroding the federal budget and causing great national concern.

- Between the years 1960 - 75 there was a 45% rise in hospital admissions, with a cost increase per day for patient expense of 266%.

- Medicaid and Medicare programs account for more than 72% of the rise in public spending, with 60% going to hospitals and 13.9% to physicians of the federal share.

- Health care in the U.S. cost $40.5 billion or 5.9% of the gross national product in 1965. It rose alarmingly in 1975 to $118.5 billion or 8.3% of the G.N.P. The estimate for 1976 is $139.3 billion. (It should be noted, however, that the growth rate of the aggregate health expenditure is similar to that of industrialized western nations such as Sweden (1965 - 72) and France (1965 - 74), each with a 14% increase per year).

- The largest portion of the health care expenditures (approximately 40% or $55.4 billion) is for hospital care.

- In 1975 more than 10% (or $1,600) of the median income of the average American family was expended for health care.

That health care has traditionally not been available to poor minorities as it has been to more affluent whites is well known. Health services and health personnel have simply not been at the disposal of the "underclass" of our nation. The physician/population ratio has been disproportionately low for the black population. For example, minority groups comprised 12% of the population in 1970 and 11% of the employed population, yet blacks account for only 6% of the six leading health professions. To further highlight the disparity between health professionals for blacks vs. whites, consider these statistics from the Department of Commerce. Figures in 1970 show that there were only 26.6 black physicians per 100,000 population as compared to 146.4 white physicians per 100,000 population. The figures for dentists are just as appalling. In that year, (1970) there were 10.5 black dentists per 100,000 population to 50 white dentists per 100,000. With these startling statistics, it is no wonder that poor blacks have complained of their inability to receive quality medical service. Maldistribution of medical personnel is another problem plaguing the health care delivery system – making services out-of-reach to many. Urban areas have a physician/population ratio five times higher than small towns and rural areas. In addition, the highly trained physician specialists are more often than not located in large metropolitan areas.

There is, however, reason for optimism. By 1974, (presumably due to the advent of Medicaid and Medicare) physician services to the poor had increased. And in a two-year period that portion of minority/blacks who had *not* seen a physician in the past two years had dropped from 33% to 19%. Further, the rate of use of physician services was somewhat higher for the poor than for the remainder of the population.

The goal of providing quality medical care to all citizens in the U.S. at a reasonable cost is certainly a formidable one. Nonetheless, attempts on the part of the Administration to accomplish this objective must be encouraged.

I strongly feel, however, that the emphasis on the costs for health care has in many ways prevented appreciation of the gains made by the so-called "costly" programs (Medicaid and Medicare). Just as a major segment of the population begins to catch-up in medical care, attempts are being made to curtail those programs which, for the first time, met some of the needs of the poor. Taking into consideration other factors which contribute to the general health of minorities – increased job opportunities, educational advancement, higher wages, we have synthesized the following recommendations:

1) *Policy* - the federal government must establish unequivocably by deed that quality medical care for *all* Americans is an inalienable right.

- There is a need for greater coordination of federal health programs.

- Inclusion of qualfied trained minorities in all levels of decision-making in health is a necessity, and educational programs geared to training minorities skilled in health planning should be developed. (It is extremely disturbing that in our quest to acquire hospitals to meet minimum standards in the U.S. Territory of the Virgin Islands, we must battle with representatives of the federal government who apparently lack sensitivity to the needs of our people. Their negative stance totally disregards the pressing health needs of a 75% black population).

- Data bases for minority problems in health need to be identified and promoted.

2) *Education* - there must be federal financial support for medical school programs for minorities who will upon graduation serve for a predetermined time in rural and underdeveloped areas. Medical schools should be encouraged to initiate innovative curricula to satisfy manpower needs with and for minorities, with emphasis on satisfying specialty needs in areas of the country having a low physician to population ratio.

- Increased minority enrollment in all health professional schools must be supported.

- Incentives to physicians for participating in federal programs must be initiated.

- Federal support of health education programs at all levels of training (elementary to post-graduate) and community health education projects should be augmented.

  - - Continuing medical education for physician licensure and hospital privileges must be a requirement.
  - - Black health professionals should develop unique modules supported by federal funds for use in health education programs in low income areas.

- Expand health care programs to poor before restricting needed programs.

3)*Financing* - with the introduction of national health insurance, there should be some mechanism whereby the program would be financed by premiums for those who can afford them and by federal subsidy for those who cannot. The program should initially cover children and women of childbearing age, with an orderly phase-in of the elderly and the rest of the population.

- Community hospitals should serve as a pivotal point for health planning, by identifying unmet health needs and then developing programs of service to meet these needs.

- Regional hospitals should be established, organized for specialized care (i.e., kidney, cardiovascular, cancer, etc.), thereby decreasing duplication and impacting positively on cost benefit ratios.

- Perhaps more directly, members of this health professional group should create a national organization whose goals would include influencing legislators to establish more health programs for minorities, assisting regional and community groups in developing health plans to satisfy their priority needs, and organizing a data bank adapted to the general health needs of blacks in America.

During the past few minutes, I have attempted to present in capsule format the status of the health system in America as it affects the black population, followed by a presentation of recommendations that may be implemented to change the stormy course. The task of providing positive change is a most difficult one – one that will require the cooperation of all segments of our society. But a great part of the struggle must be borne by such well-informed professionals as yourselves.

As we are reminded by Alfred Tennyson in *Ulysses, we must be*

strong in will to strive, to seek, to
find, and not to yield. It may be that the gulfs
will wash us down
it may be we shall touch the happy isles . . . .
but something ere the end,
some work of noble note may yet be done.

ON THE INDIVIDUAL AND POLITICAL INVOLVEMENT OF HEALTH PROFESSIONALS IN HEALTH MAINTENANCE

THERMAN EVANS, M.D.
National Health Director, Operation PUSH

INDIVIDUAL BEHAVIOR

A model is a person or thing regarded as a standard of excellence to be imitated. In the field of education we know that modeling is one of the most effective ways to educate people or to teach people a new way. Young people will listen to what you say, but they also see what you do. If we are seriously concerned about dealing with the health problems that our people are confronted with, we must take very seriously the fact that all of us are models. Many of us are models in different ways. Some of us are models of perseverance, some of us are models of energy, some are models of arrogance, some are models of confidence, some may be models of laziness, some may be models of ineptness. Some of us certainly are models of success. By virtue of the fact that there are extremely limited numbers of black professionals in the area of health in this society, all of us are models for our youth, whether we like it or not. We are models whether we accept it or not. The question, of course, is what kind of models are we? Most of us are health professionals, the people on whom our people depend and look to for health information, health education, and for maintaining some kind of consistent medical care. *We are the models.* Look at us, the models. I want each of us to say to ourselves, "I am a health role model." You may not believe it, you may not accept it, you may not want that responsibility, but it is yours regardless.

I am very concerned about people involved in improving the health of people who have little regard for their own health. What do I mean? Nutrition, we know, is related to all major illnesses in this society. Yet we have very little regard for what we put into our bodies and very little regard for the fact that we are models and people watch what we eat and what we do. We know for example, that nutrition is related to obesity, high blood pressure, cancer, heart disease and diabetes. It is related to at least six out of the ten leading causes of death. Nevertheless, every year on the average, each of us consumes approximately 125 pounds of sugar, 129 pounds of beef, 295 twelve-ounce cans of soda pop, and 5 pounds of food additives. These eating habits contribute to our ill health. *We are the models.* We have very little concern about what we put into our bodies, and in that situation, certainly, eventually, what we put into our bodies will give us something to be concerned about. We must stop digging our graves with our teeth. To further illustrate the connection between diet and disease it's appropriate to speak of specific diseases. When the diagnosis of high blood pressure is made for a patient, one of, if not the first thing that happens is that the individual is counseled to do two things: cut out or cut down on the salt and lose weight. A significant amount of hypertension can be controlled with just those two diet-related steps. If that is the first thing that happens *after* the diagnosis is made, why not tell people to do that up front? One of the first things that happens after the diagnosis of diabetes is made, is counseling to cut down on sugar and carbohydrate consumption, and lose weight. If that happens immediately *after* the diagnosis is made, why not do it up front? We would be dealing with much less high blood pressure, much less diabetes. *We are the models.*

In addition and related to our eating habits, we have unfortunate economic habits which contribute to our ill health. What do I mean? I mentioned that the average American consumes 295 twelve-ounce cans of soda. Black people represent, in this country, between 11 and 15 percent of the population. Most of us are said to be poor. Yet we consume 49% of all the grape soda produced in this country. Though we represent between 11 and 15 percent of the population, most of whom are said to be poor, we consume 30% of the entire soda pop industry – Coca-Cola, fruit punch, grape soda, orange soda, root beer – you name it and we buy it. It is rumored that the people at Coca-Cola say in terms of sales of coke, "we are the real thing." We represent between 11 and 15 percent of the population, yet we consume 24% of the Old Forrester market, 16% of the J&B market, 12% of the Chivas Regal market, and between 25 and 50 percent of all the scotch consumed in this country. Now the tragedy of this is, none of it does you any good; none of it does your health any good, at all, at any point in time. It is important for us to note that poor people can keep in business multi-million dollar industries which do nothing but contribute to our ill health, for which, when we are hospitalized, money must be taken from those same poor pocketbooks to pay for the escalating costs of medical care. Something is wrong with that. *We are the models.* A further tragedy is, that at the same time we provide millions for the support of multi-million dollar industries, the products of which do nothing positive for our health, our predominantly black educational institutions across this country are struggling desparately to survive. How many of us contribute to them.

A couple of years ago, the NAACP started a drive to collect $1.5 million from the black community. They could not do it. But we can spend millions in support of multi-million dollar industries. We can spend almost $100 million a year buying scotch, while the NAACP, the forefather of civil rights organizations, cannot collect a mere $1.5 million. Something is wrong with that. *We are the models.* Simultaneous with our support for multi-million dollar industries, black students are crying for, and struggling to get, money to go to school. We have a habit of buying what we want, and then we turn around and beg for what we need. That needs to be changed. We can do better; certainly, we have the responsibility for taking the lead since we are the models. If we who know better don't do it, we cannot expect the brothers and sisters who do not know better to do it. We must take the lead. There is another unfortunate aspect of our personal life styles. No exercise! We live in a sedentary society that has gotten away from exercise. And it shows. I ran a three-mile run this morning with Congressman Dellums, Congressman Fauntroy, a few media people and over a hundred people from the Southeast D.C. community who wanted to come out, promote physical fitness, and do something to keep themselves healthy. Exercise we know, helps to do those things. If we improve our diet and increase our exercise, we could do a lot toward preventing many of the major illnesses that we are confronted with. We don't need a host of new doctors to do this. We don't need a host of new dentists and nurses to do that. We are not assuming the responsibility of fostering what we already know. I am not afraid of working myself out of a job; I don't think that will happen in my lifetime. But I am concerned about keeping people healthy and I think more of us need to accept that responsibility. We can only deal briefly with each of these areas so we move from the individual to the political level.

POLITICS OF HEALTH PAST

Politics is the art of effecting and affecting policy. When talking about politics we must talk about priorities. I had a conversation recently with a few friends of mine. We talked about the civil rights movement and the socioeconomics of black people. During the conversation, one friend said, "blacks are no longer priorities in the system." I thought about that for a minute and I said, "well I'm not sure I remember when we ever really were." I tried to, but I could not come up with when we ever were really a priority. Why do I say that? Because the federal government, government of all the people, has not in the past, and does not now, treat blacks equitably. I make this statement based on the federal government's record of treatment of minority people and institutions. Though there is often a problem retrieving the information, the government tends to document everything. One of the things I think is well known in the bureaucracy is, the thicker the document and the finer the print, the less chance anybody will read it. And so why not write everything down? In the Forward Plan for Health FY 78-82, H.E.W. mentions many times that priorities must be needed, affordable, and doable. I find that interesting. That phrase is mentioned very often – "priorities must be needed, affordable and doable." Reflecting on the health problems of black people, I say to myself, certainly we feel our health problems are a priority. We feel their correction is needed, and in this the richest country in the world, they should be affordable. And the answers to 90% of the health problems we are confronted with are known. So they are doable. But they remain. While working at H.E.W. in 1971, I had a chance to read a memorandum entitled, "On The Health Status of America's Non-Whites." It made me feel that perhaps at this point, there was some sensitivity to the health problems our people face. I read, in that memorandum, a brief quotation that is a relatively accurate assessment of the health status of black people today. It says:

> *The community's survey does not include data for Negroes. It is well known, however, that ten percent of our population, who are colored, have health problems which are on the whole considerably more serious than those of whites. The Negro is America's marginal worker, and he suffers in the north as well as the south, from the many disabilities that this entails, poor housing, less adequate diets, less sanitary surroundings, more employment of married women, and greater economic insecurity. The extensive migration of Negroes during the last 20 years has added new complications to their problems. Although Negroes have lower death rates than whites for a few diseases, rates double or more than double the rates of whites are recorded for tuberculosis, organic heart disease, acute and chronic nephritis, cerebral hemorrage, pneumonia, typhoid fever, whooping cough, bronchitis, puerperal conditions, influenza, malaria, and pellagra. Not only are death rates higher, but so also is the incidence of illness.*

Reading the memorandum further down, it said that the quotation was extracted verbatim from a report done by a committee called The Committee On the Costs of Medical Care, which submitted its report in the year 1932. Words written over four decades ago accurately describe the health status of black people today – the health status of poor people today. We are *not* a priority. Out of curiosity, I tried to find out what that quotation was based on and came up with a document called *The Health and Physique Of The American Negro*, written by W.E.B. DuBois in 1906. Words used many years ago can be used today to describe the health status of our people. Something is wrong with that. Certainly, we are *not* a priority.

POLITICS OF HEALTH PRESENT

What are the present indications that blacks are not a priority? Let's look at the National Institutes of Health, for example. The NIH has a budget of approximately $2 billion a year. Coming from a poor black family I have no concept of what a billion dollars is, but I read an account once which helps me to understand it. It said, if you were to dig a big hole in the ground, and every minute you dropped in one twenty-dollar bill, it would take you 98 years to put in one billion dollars – 98 years. The budget of NIH is twice that, all of which money comes from tax dollars. In 1971, the NIH gave more money to the University of Alabama than it did to all of the 112 predominantly black colleges and universities combined. In the same year, it gave less money to over 100 of the predominantly black academic institutions than it did to New Zealand, Australia, and South Africa. These are our tax dollars I am talking about. This is what is happening to us at the political level. It happens first because we do not know about it, and second, once we learn about it, we do not move to change it. In 1974, I decided to check on the progress NIH was making in distributing my tax dollars. I wrote to the Director, who sent to me the latest available information, the FY 74 Annual Report – a very thick document. Examining the document, I found that 17,327 grants were awarded – totaling $1,329,880,660. Out of those 17,327 grants, 99 or .6%, went to all of the 112 predominantly black institutions. Out of the $1,329,880,660, $10,400,000 or eight-tenths of 1% went to all of the predominantly black institutions combined. We contribute our tax dollars but we don't get them back. In 1976, I decided to check again on the progress of our federal government and I got a document back which told me that now $10,800,000 was going to all of the predominantly black institutions – very little progress. And only 54 of them, as opposed to 99, in '74, were receiving any money at all. The Food and Drug Administration, with a budget of $600 million, identified only seven groups in the years 1975 and 1976, that were, as they call it, black-oriented, that received any money at all. In FY 75 that totaled $618,000 or one-tenth of 1% of the dollars. In FY 76, it went down to $466,000, less than one-tenth of 1% of the dollars. The Health Resources Administration in FY 75 indicated they had 607 total dollar actions. Out of that 607 total dollar actions, 18 went to 8(a) contractors; that's 2.4% of the total. The 607 total dollar actions totaled $59 million. The total for the eighteen 8(a)contracts was $1 million or less than 2% of the total dollars. For FY 76, the statistics are the same, and yet in HRA, they have black groups focusing on OHRO, the Office of Health Resources Opportunity, the only office directed predominantly at minority organizations. OHRO has less than 4% of the total resources of the Health Resources Administration. While they have us focusing on the director of OHRO and fighting the rest, some 99, 98, 96 percent of the resources are going off elsewhere. *Something is wrong with that.* It's a very classic psychology. We must wake up and think about what's happening to us. We are fighting over the only office which directs all its dollars to minorities: we are fighting over 4% of the resources. The Health Services Administration, in FY 75, gave less than 1% of its grants and contracts, and less than 1% of its dollars to predominantly black institutions. In FY 76 the Health Services Administration gave less than 1% of its grants and contracts to predominantly black institutions, less than 1% of dollars followed. The report sent to me indicated that there were four Advisory Councils of the Health Services Administration. These are the bodies that determine how much money goes where and to whom. Listed were the National Advisory Council on Migrant Health, two of whom were black; the National Advisory Council on Health Manpower Shortage Areas, one of whom was black; Maternal and Child Health Research Grants Review Committee, one of whom was black; Interagency Committee on Emergency Medical Services, none of whom was black. Yet we focus on the Office of Health Resources Opportunity. We have heard many times the statistics that are relevant to the health system and how much money we are spending, so I will not go over those. We have heard many times the health statistics relevant to the black community, so I will not repeat those.

Another present indication that we are not and have not yet been a priority is the *Bakke* case. We still live, for those of you who may not be convinced, in a racist and discriminatory society. Most of us, hopefully, know that. In a society where racism and discrimination are practiced, you expect racism and discrimination to be practiced by those who practice it. If you see an animal that has long ears, short legs, a wiggly nose with gray hair and a white cotton tail, you say to yourself that's a bunny rabbit. Since you expect a bunny rabbit to hop and wiggle its nose, no one is surprised when a bunny rabbit hops and wiggles his nose. Why then do we act surprised over the behavior of racists in a racist society. Acting surprised, we spend energy that we could spend organizing politically to deal with a situation that should be expected. Reverse discrimination has never been the issue since the old forward kind hasn't stopped yet. Bakke was turned down by ten different medical schools; some of the minority students who came in under the special program had higher grade point averages, and higher aptitude scores than he did; in addition there were many white students who had lower scores but were admitted. So Bakke is doing just what ill meaning whites, or, I should say, what politically astute ill meaning whites have always done. They pick on the weakest. Why didn't he pick on the fact that the dean had five slots set aside for the so-called wealthy; the people who contribute to the sustenance of the University? Why didn't he say those are special slots? Why didn't he pick on them? Why? Because they are politically organized and you'd better not do that. You don't do that. So he picks on the weakest, and this is what has always happened. We are the weakest politically, socioeconomically, philosophically and academically. We are the weakest. So naturally, if you want to win a fight, you pick on the weakest. It's just that simple. So until we get ourselves together, we will always be picked on. One thing I very much respect is the way Jews in this society have come together. If one congressman or state legislator, somewhere in the state of Montana, Arkansas, or Mississippi, says anything that is considered anti-Semitic, the next morning there will be hundreds of thousands of letters on that person's desk. But you let somebody step on the foot of a black person somewhere, let someone try to wipe out Meharry University Medical College somewhere, and what happens? We must get to the point where if one of us gets a foot stepped on in California, in Washington, D.C., I must say "ouch!"

I would suggest to us that we as a people do not write – we do not write and we do not speak our opinions. That is not an opinion, it is a fact. It has been proven time and time again. I was in a meeting with Secretary Kissinger just after he returned from Africa, where he announced what even he considered a mild African policy. He announced the policy in Africa. By the time he got back to Washington, he had 1,723 letters – he said 1,700 of those letters were opposed to the African policy and 23 were in favor. The first thing any politician does anywhere is quote "what my constituency says." We must become a constituency. Ralph Ellison called us the invisible people and certainly we are, for we have not made ourselves visible and I say that must come before anything else. I said earlier that I may say some things some of you may not like. It is difficult for me to suggest to you how you can clean your house, when mine is awfully dirty. It has been said you cannot blame the victim for his or her plight. We must not blame the victim and certainly blacks in this society are victims of racist and discriminatory practices in the past. One thing is very clear; the victim may not be responsible for being down, but the victim is certainly going to be responsible for getting up. That is very clear. That's why we are victims in the first place – because somebody has his foot on our necks because he wants to have it there. We can say, "please sir get your foot off my neck," but that will not help. We must organize and get that foot off our neck. I'm not talking about all sorts of crazy, wild revolutionary schemes, I'm just talking about being visible, I'm talking about saying something, writing letters to our representatives in Congress, making our voices known, making our opinions known. We just do not do that. Senator Kennedy, and Congressman Corman at yesterday's beginning session, made it very clear, time and time again, "please write us and let us know what you are thinking." Will we do that? That is the question. In the past we have not. We have a responsibility to do that. We suffer sometimes from a syndrome in our society, called, "I am only one person, what can I do?" This syndrome is characterized by the fact that we fail to appreciate the contribution of small things towards the solution of big problems. Of course, while I am saying that, in my small corner of the earth, 30 million others of us across the country are saying the same thing, individually – "I'm only one person, I can't fight City Hall, I can't fight the bureaucracy, I can't deal with it, so therefore, I'll back off and do my little thing, and move and groove in my own little pathway." The net effect of that is zero. If the reverse were true, I am one person, I am here, I must make a difference, therefore, I am going to sit down and write my letter; I'm going to write my letter and make it clear what I think about it; and I am going to get other people to do the same thing. Multiply that times 30 million and we will have something going on. Martin Luther King, Jr. was not 150 thousand people; he was only one person who believed in himself and was committed to getting something done. W.E.B. DuBois was not two or three or 100 thousand people, only one; Sojourner Truth, Harriet Tubman, only one, but they believed that they could do something and they operated out of that philosophy and sure enough something was done. Malcolm X, only one person, Jimmy Carter, only one person. Nobody in their right mind thought Jimmy Carter would be president today. That is, nobody but Jimmy Carter. He believed in it, he operated as if he did and, sure enough, the President today, they tell me, is Jimmy Carter from Georgia. If it is believable and conceivable, it is achievable.

A basic law of nature is that when people cooperate, things get done. Look at the human mind and body. The cardiovascular system has a very distinct and definite function. It is there to pump that blood, and supply those nutrients and oxygen to the rest of the body. And yet the cardiovascular system can do nothing without the respiratory system. The lungs are there to breathe, take in that oxygen and put out that carbon dioxide. It is there, with a very definite and distinct function, yet the respiratory system can do nothing without the gastro-intestinal system. It is there, it has a very definite function, it can do absolutely nothing without the central nervous system, the quarterback, determining the moves and the grooves the body makes. Every one of us has a very distinct and definitive function and role to play in this medical care system. Each of us must do our job. If the heart decides to stop working, then the body doesn't move. If the stomach decides to stop working, the body is compromised. If the brain decides to stop working, the body is compromised. All of us have a job to do. Each of us must do it. We must appreciate the importance of what we are doing. We must be concerned about keeping people healthy versus just treating them after they are sick. We must be concerned about prevention in this society. Unfortunately, we are too hung up on curative medicine. I am very much concerned about us, as the models, falling into that very same pattern.

I will close utilizing the titles of the soap operas that I see every day. There are messages all around us that we could collect, but we miss them because of the finger-popping that goes with them or because we are so concerned with who's going with whose wife. We miss the real message. If you look at the titles to the soap operas you will find that there is clearly a message, and it says, too many Days of Our Lives have been spent at the Edge of Night. We must all begin to act as if we are Young and Restless in our Search for Tomorrow, for As the World Turns, be clear that we have but One Life to Live, and with it we must be The Guiding Light in the struggle to build Another World for us and for All Our Children.

SUMMARY OF WORKSHOP RECOMMENDATIONS

1. That a national financing scheme for health care be established that is comprehensive, universal, and contain no deductible or co-insurance requirements. Such a scheme should not be financed through employers only, nor structured like the present national and state Medicaid program model, and should offer no tax credit option to any group;

2. That an effort be initiated to coordinate all existing data related to blacks in federal agencies and private organizations, so that an appropriate base might be established for the development of policies and programs responsive to their health care needs;

3. That cost containment initiatives and regulations focus on long-term cost reduction measures which emphasize prevention and link medical care policy to social services policy;

4. That federal cost containment guidelines allow for more effective use of non-physician health care professionals and the use of existing low bed occupancy hospitals by already established and newly proposed HMO's and health plans;

5. That federal regulations require:

   - greater formula equalization for cost reimbursement between private and public hospitals for the care of Medicare patients,

   - greater flexibility of standards among hospitals to allow selected exemptions based on patient mix and the resulting facility utilization, and

   - appropriate safeguards to prevent private institutions and practitioners from shifting costs from themselves to municipal, rural and public institutions;

6. That the federal government initiate a national educational effort to better inform minority and low-income populations about the various voluntary and government health financing schemes;

7. That an additional tax on liquor and cigarettes be mandated through federal legislation as a source of funds for implementing programs in preventive health care;

8. That amendments be made to PL 93-641 which would allow consumers to have the legal right and persuasive authority to control health planning policies in their service areas;

9. That Howard University and Meharry Medical Colleges and other selected traditionally black institutions become centers of consultation on black health concerns commensurate with the intent of PL 93-641; and

10. That black involvement be required on HSA and SHCC boards and staff where they comprise a significant proportion of their service areas.

WORKSHOP I

NATIONAL HEALTH INSURANCE:
WHEN & HOW, & WHO OR WHAT ?

LEADER:

Everett Fox, MBA
Vice President and Administrator
New York University Hospital
New York City

FACILITATOR:

Jim Crawford
Committee for National Health Insurance
Washington, D.C.

OBJECTIVES FOR WORKSHOP I

NATIONAL HEALTH INSURANCE: WHEN & HOW, & WHO OR WHAT ?

The increasing costs of health care, in terms of hospital expenses and physician fees, have exposed the need for a national health financing plan – a plan long overdue. The myriad proposals that have appeared before the Congress, representing the vested interests of select groups, have failed to address many of the fundamental issues relative to access to health care for black Americans and other neglected groups.

SPECIFIC OBJECTIVES

1. To update program participants on the legislative status of NHI develments in this country;

2. To analyze the features of existing proposals with respect to key variables:

    - Universal coverage,
    - Availability,
    - Accessibility, and
    - Reorganization of the health and medical care system;

3. To determine if a national health insurance policy is the most feasible form of health financing for black America, i.e., national health *insurance* or a national health *service;*

4. To develop recommendations for input to the formulation of a national health policy, with specific reference to black America; and

5. To conduct preliminary analysis of costs and benefits:

    - Who will benefit from any proposal?
    - What will the benefits consist of?
    - How will the benefits be paid for?

SUMMARY OF WORKSHOP I

This workshop emphasized Objectives 1 and 2. Participants stressed the need for more black input at the national level, organized around the issues of National Health Insurance and a National Health Service.

The introduction by Mr. Fox summarized the major national health insurance proposals that have been submitted to the U.S. Congress, including Congressman Dellums' bill, HR. 6894, A National Health Services Act.

The participants in this workshop did not realize that some 50 "national health insurance" proposals have been offered at one time or another. As a result, the group thought they needed to concentrate more on the specifics of national health insurance or national health service before addressing objectives 3 and 4.

There was an interesting discussion of whether the Kennedy-Corman Bill, S.3, or the Dellums bill would better meet the health needs of the black community. Acknowledging that the Dellums bill is what this country really needs, it was felt that in the short term, passage of such legislation is not politically feasible, and that the Kennedy-Corman Bill is the only feasible alternative at this time. The implementation of such a program as suggested by Congressman Dellums was considered by the participants to be some 20 to 30 years away.

Although the issues discussed in this workshop have been raised many times over the past decades, it was pointed out that all proposals for national health insurance deal with financing the health industry, and do not deal with national health policy in the same positive manner as the Dellums bill.

Participants recommended that any national health insurance measure be:

(1) Comprehensive,
(2) Universally accessible, and
(3) Free of any deductible or co-insurance requirements.

The group also recommended a strong educational drive for the black community and others about the benefits, costs and political consequences of proposed national health insurance schemes versus a national health service, pointing out that the United States is the only industrialized country other than South Africa without some type of national health insurance system.

Finally, it was strongly recommended that action be taken to ensure that the current administration does not propose an innocuous national health insurance bill that will set back even further the adoption of a national health policy.

WORKSHOP I

National Health Insurance: When and How, and Who or What?

Leader: Everett Fox, MBA, New York University Hospital, New York City

Facilitator: Jim Crawford, Committee for National Health Insurance, Washington DC

MR. FOX: We are about ready to start. I am overwhelmed at this less than overflowing crowd.

After the previous discussion, I think the comment was made by my namesake, Dr. Fox, that he felt that nothing is really going to happen to national health insurance, so people might have felt, what is the need of hearing something more about national health insurance. But I certainly appreciate your attendance, and I believe I am supposed to attempt to convey to you some of the issues involved in national health insurance, and then have you to tell us some of your ideas. Before starting, I would like to recognize Mr. James Crawford, who will be assisting in this workshop. He is employed with the Committee for National Health Insurance here in Washington, D.C.

So with that brief introduction, I will get into my own comments. One of the most complexing problems facing President Carter's Administration and the nation today is that of national health insurance. Most health literature and most conferences being held on the subject seem to conclude that the fundamental health goal for this country should be that all Americans, regardless of ability to pay, have equal access to available health services. Some may not agree that all should have equal access. However, those who do agree realize that comprehensive health planning – and you certainly have heard that word enough – is a key factor; that services should be provided only after sound planning has been undertaken.

What health issues should we plan for, and how big is the problem? Current information, as of June 1977, reveals one grouping of the population, those 45 to 65 years of age, over 96 million people in this country, who suffer from chronic ill health. This is close to 50 percent of the entire population. Edward Yost states: "More than 72 percent of the population between 45 and 64 years of age, and 86 percent of persons 65 years and older, have chronic health conditions." Chronic ill health and income are closely related. It cannot be stated with confidence which is the cause and which is the effect. That is, does chronic ill health cause low income-producing capability, or is the low income a factor in producing ill health? These figures tend to demonstrate that our working population is highly vulnerable to illness during that important phase of life, the second half of the employment cycle.

Until the illness rate is lowered, and even afterward, it is imperative that some medical assistance be extended to our citizens. It is not very comforting to read that at its best, you can't find better quality care in the world than that given in the United States, but that when you don't have the money to pay for it, you may get mediocre or poor quality care. In planning, steps must be taken to eliminate the existing deficiencies in the system. Mediocre or poor quality medical care should not exist.

At the beginning of my remarks, I stated we would strive to reach our health goal within the resources that are available. What is available, or what should be made available, has yet to be established. Let's take a look at some interesting statistics. Total expenditures for health care in the United States reached an estimated $140 billion in 1976, and $160 billion in 1977. Hospital and physician expenditures rose to almost $82 billion. Federal, state and local spending for health care reached $59 billion. These are staggering figures, and coupled with existing trends – high inflation, for one – may dictate the range of services affordable. National health insurance, sometimes referred to as NHI, is certainly not a new program in this country. It is known that the Federal Government became involved in a phase of national health insurance almost 180 years ago, in 1798. This program was developed in an effort to provide merchant seamen with care. The very first Congress established a compulsory insurance program for these seamen, and required them to pay the costs through monthly contributions. It would appear, then, that we should perhaps have developed, prior to the 20th Century, some slightly expanded form of national health insurance.

Unfortunately, we are last among the major industrial nations of the West without any definite, comprehensive national plan to help our citizens pay for and get adequate medical care. This is not to say that we have lacked interest, for the issue of national health insurance has consistently been a feature, in one form or another, of limited or prolonged discussions in federal administrative forums. We recognize that an NHI plan is a complex subject, but it is felt that the experience gained from the implementation of Medicare and Medicaid in the mid 1960's provided us, to a degree, with significant data on potential national health plans. As was anticipated, these programs carried the stigma of the much feared phrase, "socialized medicine," and were considered by some to be losers from their inception. Hopefully, we have overcome the psychological strain, as well as mistakes in planning that were apparent in these two programs, and will develop a health insurance plan or a health service program that will be consistent with the basic principles which have already been set forth by President Carter. These principles include:

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1) Inclusion of preventive health care services, particularly for children;
2) Equality in our health care system, and thus a universal and mandatory health insurance or service;
3) Management efficiency;
4) Quality assurance mechanisms;
5) Citizen-consumer participation in administration, and community participation in decisions about health care services; and
6) Coordination with welfare reform plans.

As a result of renewed and increased activity on health issues in the past two or three administrations, 14 major bills were introduced in the 92nd Congress. We must now honestly answer the question: Is this country ready to bite the bullet? Is it ready to face up to national health insurance? There are at least 57 proposals that will be debated during 1978, representing a big step toward developing an acceptable medical care program for all. It is our information that the new Speaker of the House, Thomas P. O'Neil, will play a key role in the passage of any health insurance measure. Some of his comments have been that the first stage of new health care services "probably" would be in some form of catastrophic health insurance. However, he further stated, and I quote him, "We are going to move slowly, and we are going to make sure we are fully funded each year." This is looked upon as support for President Carter's announced intention to balance the budget by 1980. Now to the proposals.

In the literature reviewed regarding NHI, the following are some of the legislative proposals analyzed, or evaluated, by scholars in the field of health. Today, you may wish to further analyze these programs, elaborate on their merits, or introduce to the group your views on a national health plan. As stated earlier, 57 health insurance bills have been introduced in the first session of the 95th Congress. No action has been taken on these bills thus far, and consideration of them probably will await the introduction of the President's proposal next year, if there is a proposal. I ask your indulgence as I take you briefly through six of these proposals. They are:

- the McIntyre bill,
- the Broyhill bill,
- the National Health System,
- the National System of Health Security bill,
- the Long-Ribicoff bill, and
- the Ullman bill.

You will note that some of these bills have similar features, as well as similar titles.

Let's examine the *Burleson-McIntyre Bill* first. This bill proposes three voluntary health insurance plans which would include an employee-employer plan, an individual plan, and a plan for the poor and uninsurable. After a phase-in period, all plans would provide a broad range of health care services with benefits generally subject to cost-sharing by the patients. All plans would be administered through private insurance carriers, with overall program supervision by the state and federal governments. The qualified employee-employer plan, and the qualified individual plan, would be financed by premium contributions, and the contributors would receive tax advantages.

The most comprehensive proposal, The *National Health Security Act of 1973*, would be financed primarily by federal and state general revenues. The bill includes various provisions designed to increase the supply of health manpower, the development of ambulatory care centers, and the expansion of health planning. The various state insurance departments would approve the policies established by the private carriers, and each state would establish a health insurance pool. Premium rates for the state plans would be determined within each state, subject to review by HEW.

The *Fulton-Broyhill Bill* has been identified as the Health Insurance Act of 1973, and is known as Medicredit. It is designed to encourage the voluntary purchase of qualified health insurance plans by granting tax credits against personal income taxes to finance part or all of the premium costs of the plan. To qualify for a tax credit, an eligible individual would have to purchase a plan or plans providing certain institutional, medical and dental benefits, and the catastrophic expense coverage specified in the bill. The amount of tax credit would include 100 percent of the premium or a portion of the premium charged for catastrophic coverage, and an income-related percentage of premiums paid for other health benefits required in the bill. In addition, the bill would provide for federal payment for premiums for qualified health insurance policies for individuals or families with no tax liability. Such individuals would receive from the government a health insurance certificate which would be used to purchase a qualified health insurance plan from private carriers. The American Medical Association originated this bill. It has since been withdrawn from the House.

A National Health Service. The Medical Committee for Human Rights developed this concept in 1971, the architect being Dr. Tom Bodenheimer. Subsequent to several revisions, Representative Ronald Dellums, Democrat of California, saw to it that two of these revisions appeared in summary form in the Congressional Record on October 17, 1974 and May 19, 1975. The Dellums' plan supports the thesis that health care is a human right, and that it is thus a necessary function of national government to establish a community

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based system of health care. I would like to make available to you a description of this plan, as reported by Louise Lander from the Congressional Record of March 1975, and a draft dated February 27, 1975 of the Health Rights and Community Health Service Act. The plan would establish a network of service areas, communities, districts, and regions, and a corresponding government structure of service area health boards. Services would be structured on a regional basis, corresponding to the service areas, with community health services at the community level, general hospitals at the district level, and medical centers at the regional level. The system would be financed by a series of taxes on corporate profits, personal wealth over $50,000 and personal income over $20,000. These revenues, plus general revenues as necessary, would go into a national health care trust fund. Allocation of the funds to communities, districts and regions would be set forth in an annual program budget developed by the Finance Committee of the National Health Board. This budget would in part be determined by a formula based on population, age distribution, need for health workers, and other health resources and special needs reflected by epidemiological indices. Modifications could be made in the standard formula by the national board, based on plans and budgets developed at the community, district and regional levels. All services would be free at the point of delivery to all persons within the United States and its territories.

Now to the *National System of Health Security Bill.* This bill has been referred to as the Kennedy-Corman bill. It would provide for the establishment of a national health insurance program covering the entire population and offering a broad and comprehensive range of services. For covered services, there would be no cutoff dates, no coinsurance, no deductibles, and no waiting periods. This program would be financed by a federal payroll tax on employers and employees, a tax on unearned income and self-employment earnings, and by federal general revenues. This bill would create an administrative structure within HEW to be charged with the administration of the program. The proposal includes study and evaluation provisions, economic incentives, and grants and loans aimed at reorganizing the delivery of health care services, improving health planning, and increasing the supply of health care manpower and facilities. The bill would also allow for reciprocal and buy-in agreements to cover certain non-residents, aliens, and in some cases U.S. residents traveling abroad. This bill would terminate Medicare and the federal share of Medicaid.

Now the *Long-Ribicoff Bill.* This bill was originally introduced in 1971. The bill supports compulsory catastrophic illness and insurance for all social security beneficiaries. It is a federally administered public plan for the unemployed, welfare recipients, the aged, and persons who do not opt for alternate private insurance coverage. Under Title 1 of this bill, the emphasis is on catastrophic illness, and it would automatically extend benefits to all those covered by the social security system. Title 2 of this proposal supports medical assistance for the poor through a federalized medical assistance plan to replace Medicaid. Title 3 establishes a voluntary federal certification program intended to encourage the insurance industry to make basic health insurance coverage universally available. This plan also would supersede Medicaid. However, the Medicare program would continue as currently administered.

The *Ullman Bill* is a three-part program covering the entire population. There is a plan requiring employers to provide private coverage for employees, a plan for individuals, and federally contracted coverage for the poor and aged. The state establishes a health care plan, supervises carriers and insurers, according to federal guidelines, and promotes a system of chartered health care corporations known as HCC's. This plan is supported by the American Hospital Association. There would be designated benefits for institutional services, personal health services including physician and dental services, drugs, medical equipment, and eye glasses, with coinsurance featues. Medicare would be abolished. Medicaid would not pay for covered services. All providers and HCC's must establish systems of peer review, medical audits, and other procedures to meet federal-state requirements on quality and utilization of services. John McMahon, the President of the American Hospital Association, states that the AHA has chosen to use the term "universal health insurance" instead of "national health insurance," since the latter term is generally viewed as a government program totally financed by taxes. The AHA supports a pluralistic program funded through a multiplicity of sources – that is, both private and governmental, with a phase-in approach to the universal health insurance program. The basic goal of the plan, states McMahon, "is the removal of financial barriers that limit access to health services for the various segments of the population." He further states that "the association plan has addressed the problem of rising costs of health care, of access to health care services, and inefficient regulations." McMahon feels that the new AHA plan places increased emphasis on health manpower, planning by state and local agencies to identify health manpower needs for given geographic areas, research on the effective and efficient use of health manpower, and education to ensure the production and maintenance of the proper types and numbers of skilled health personnel to meet the demands of the delivery system.

There are certain similarities among these proposals: all recommend coverage for all residents; benefits range from no limitations to phased-in benefits over a ten year period; administration would be through a combination of private insurance company participation and government allowances or total federal administration. Financing would be achieved through taxes or premium payments by employers and employees, and Medicare would be abolished in two of the proposals and ratained in the other three. Some of the statements recently released by the Nashville Chapter of the National Association of Health Services Executives regarding national health insurance, and submitted to HEW are quite important, and I quote two:

> *Perhaps insurance is not the answer, but rather a national health system or service which utilizes the existing non-governmental financial intermediaries. If this approach is used, the federal government could then properly focus its attention on who gets care, when, how much, and how good. Our association feels that the federal government should do what it can do best, establish a national philosophy on policy and priorities, regulate in order to see that the American people are getting what we pay for. We had rather see the bureaucracy spend more time monitoring the quality of health care and impacting the delivery system than auditing bills and requiring forms.*
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> *Within the framework of a definitive national policy for health services, costs and quality will strike a natural kinship. We believe strongly for the health dollar. The realities of economic and social responsibility are driving us to consider our health care problems from a national perspective. Implementation of any of these proposals should follow the same course of consumer participation as in the design of the plan. It should be realized that we must take it to the people and let them become a part of helping to decide what is the healthiest program for them.*

In August 1977, in a background paper on Health Differentials Between White and Nonwhite Americans, Alice Rivlin states:

> *In order to reduce white/non-white health differentials and better meet the needs of non-whites, federal programs would have to address four types of problems: financial barriers to the receipt of health services; non-financial barriers, including lack of providers and discrimination against consumers; [illegible]ce of continuity when services are provided; and insufficient empha-[illegible] some conditions affecting non-whites. Thus, approaches for dealing [illegible] remaining problems would include not only increased financing, but [illegible] reallocation of resources and the ability to provide services directly when the private sector falls short. Medical and health services comprise only one facet of our health picture, and to correct only them is not sufficient. Tnere are many health determinants that play a significant role in*

> *limiting our health achievements. They are inadequate housing, improper nutrition, environmental hazards, lack of education, especially health education, and high unemployment. Attention must be given to them and solutions must be found to either eliminate or correct them.*

Supporting Dr. Kerr L. White's statement that "the greatest benefits to individuals and society are likely to come from improved education in human biology at the elementary school level," a better understanding of how our bodies function, and other developments in the structure of personality and human relations are likely to do more to improve the health status of populations than any other single measure. I sincerely appreciate having the opportunity to bring these issues to your attention, and wish to conclude by saying that your participation will be of value in making this a meaningful workshop. At this time, I wonder if Mr. Crawford would care to make some comments?

MR. CRAWFORD: I am going to speak just briefly; Bud McCastle made me promise that I wouldn't do any active lobbying this morning, so I am going to behave myself in that way. The Committee for National Health Insurance, which I represent, has been in this field actively now for about eight years. We endorse or we represent more than 100 prominent Americans who think that there is a health care crisis and that we need a national health insurance program to solve the problem. Now, I think I should make an addition to whatever Fox said to you. Ev said that there is only one nation in the world that does not have a national health insurance program – one modern industrialized nation. Well, to give you some idea of the kind of problems we have been up against for the past eight, ten years, there is one other nation without a national health insurance program, and that is South Africa. Now, I don't mean to indicate by this that the problem is hopeless. We have been around quite some time, and I think we have made steady progress. The committee was formed first in 1969. Since that time, we have seen substantial gains in our support. We have more than 125 Congressmen and Senators who endorse a health security plan. We have more than 200 grass roots organizations and national organizations who think that health care is a right, and lately, and I think most significantly, during the 1976 Presidential Campaign President Carter gave a full commitment to the cause of national health insurance.

Now, we have seen a few problems come up this year. I think people are concerned. It was mentioned that maybe national health insurance isn't going to go anywhere. One of the first problems we saw was a welfare bill introduced by the Administration which didn't deal with the biggest welfare boondoggle of all, the Medicaid program. Here you have a $15 billion program, much of the money and services going to the black community, much of that service of highly questionable quality, and this was not dealt with at all. We saw in President Carter's press conference two days ago that the President said,

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in effect, that he has all of his cards out on the table, that he has his energy program, the tax program. He has dealt with the B-1 bomber. But he felt that all of his cards were out on the table and he didn't see any new surprise initiatives. Immediately afterward, Jody Powell held another press conference and offered this disclaimer, saying that for urban renewal projects and national health insurance, all the President meant to say was that there would be no new surprise reforms. But I think that what the President himself said is what we have to go by, and this poses a problem, or seems to.

My personal opinion, though, is that this may be a gift. If you look around at what the private interests have been doing this year, they have their own so-called national health insurance bills before the Congress. But they haven't gotten much support. In the '74 election, the Medicredit bill lost many, many supporters; a lot of Republicans were thrown out of Congress by the voters. But the special interests – the insurance industry and the AMA – are very wealthy and very powerful, and are still a force to contend with. President Carter's postponing of this issue may be a gift; in a lot of ways we are not ready. We are not ready because we haven't really given sufficient attention to this issue and formed a strong enough coalition to combat the special interests. Every time you open Time Magazine you are going to see an advertisement for Blue Cross. Every time you turn on the radio, you are going to hear a Blue Cross advertisement or a hospital corporation advertisement saying that there is a health care crisis and the private interests are concerned and are trying to do something about it. They *should* be concerned; they are largely responsible for the crisis.

In the meantime, we have not been fighting back strongly enough. We have not been getting together enough with the black community or the hispanic community to make sure that we get our viewpoint across. Why is this important? Last year a study came out called the Trapnel study, issued by HEW. It showed that the security bill is not the most expensive national health insurance proposal, even though it is the most comprehensive. New monies would be spent, but they would be spent largely for people who had never had health care services before. What can we realistically expect from a national health insurance proposal, if one is passed? As I mentioned, health security has more Congressional support than all the other national health insurance proposals combined. The Dellums bill was just introduced, and I think it is a very good bill. But we have to look at it realistically. Is the Congress going to pass the Dellums Health Service Bill? Quite honestly, I think not. There is too much opposition. If we have been fighting so many years to get health security, which is semiprogressive – it is built on the social security system – you can imagine the troubles that the Dellums bill is going to have. I think the Health Service Act is a good act. We have to look at it step by step. And the first thing we have to do is give our full support to the Health Security Bill, recognizing health care as a right. Well, I have given my spiel. I welcome your questions. I think we should get on to the matter of resolutions.

MR. FOX: Thanks, Jim. Before we get into the resolutions, I do want to hesitate at this moment to congratulate Expand Associates for pulling this group together. I can remember about 30 years ago when about 10 or 12 of us used to sit around – not any of you in this room, because none of you are that old – and talk about the health problem. And we today don't have a data base to provide us with information. I was alarmed to hear that this morning, that we don't have information to lead us in the paths we should go in designing a health program; it is quite frustrating. I personally asked Mike Holloman to stop by this session, because I have been close to Mike in New York. We haven't seen each other as much as we should have, but he certainly has some positive things to say about national health insurance. Some of you may have heard him yesterday, and some of you may not. I would like, Mike, if he would, to lead off the discussion, perhaps by describing a proposal or two.

DR. HOLLOMAN: Thank you very much. Of course, Jim and I share a common interest. I would certainly suggest that we recognize the need for realistic debate and for a display of the facts. We have watched the various tactics that have been used against national health insurance, and they have all been rather shallow. They have been directed to the emotions, counting on people to have such a vested interest in the past that they resist anything that suggests change. One of the reasons the legislation has failed in the past is because it has contained in its preamble a very significant phrase, and that phrase is "without disturbing the traditional methods of medical practice." The tradition is that there is a dual health care system; that we have two classes of patients, some private, some charity or clinic. And when we have no intent to disturb that tradition, as most of the legislation has, we have no way of eliminating the root cause of many problems that have been apparent for a long time.

It is an important fact that if we are going to bring about progress, we need to change some of the traditional discrimination, including racial discrimination, involved in the two-class system. My basic recommendation, if I were to make one, would be to recognize that we do need changes in the health care delivery system. The inability of the present Administration to focus on national health insurance is clear evidence of unwillingness to change the traditional practice of medicine and health care in this country. We need substantive changes in the health delivery system that would guarantee access to everybody and would guarantee the quality of care and *concern* with the delivery of care. I think we need an honest dialogue. In that dialogue, we should emphasize that the average person will probably pay less for health care under health security because he would not have to pay coinsurance deductibles. As a matter of fact, he would not even have to pay Blue Cross, which, as everybody knows, is extremely costly at the present time. So overall individual payments would be considerably smaller, as a matter of practical savings for the average person. You should make that known to the average voter. And if you can combine health security with those system changes that are essential to avoid waste and duplication, the people will recognize that health security is really quite a bargain.

MR. WICKHAM: I am Landon Wickham from New York City. It disturbs me to find out that there are 57 different national health insurance bills in Congress. I also find out about committees I had never heard of before, the Committee for National Health Insurance as an example. Do they have a local chapter in New York? Do blacks and hispanics have the opportunity to participate? If there is an address in New York that we can contact, I would like to know it. Also, can we receive briefs on some of these bills? Can such be sent to NAHSE. so their political group can start reviewing these bills? These are some of the concerns that I have. Maybe somebody else can throw out some ideas as to how we can get this information to some of the black organizations who have been involved in health care.

MR. FOX: A very interesting question. In trying to get something for my paper today, I happened to run across Charles Jackson, who is in the U.S. Office of Legislation. I told him I needed to review some of the facts about the different bills before Congress. He said he would be glad to help and he sent me this; it is a printout of all 57 bills. To answer your question, I am sure that Charles Jackson would be happy to send this to you. It is not difficult reading. As I started reading through this volume, I found out that all the bills are saying about the same sort of thing. But there are many, many bills in here that I didn't even know about. You are right, we need to know what we are talking about before we start making recommendations.

MR. WILLIAMS: Along that same line, when you are talking about the emergence of some national health insurance program, something should be done in the interim to persuade the Administration to do something about inadequacies in what has already been introduced. Also, it was said this morning by somebody from the Administration that black professionals are being reimbursed less than the white professionals. That is a shameful statement. Is it being said that the black professional is less qualified? If that is being said, we need to address that issue.

MR. CRAWFORD: Absolutely, black professionals are reimbursed less. One thing that the health security bill would do is to establish not only national standards of quality, but national standards of fee reimbursement. I am sure you know that this problem of inequality of reimbursement doesn't involve just race; it also involves where you live. If you live in a rural area and you treat Medicare or Medicaid patients you get less money.

MR. WILLIAMS: Why go about doing the job all over again when the issue is already addressed and just needs to be made to work?

MR. CRAWFORD: Well, I think you can't really say it is being addressed if these problems exist. The idea you suggest – putting in some partial program and then correcting it later – has already been done with Medicare and Medicaid, and they have been around for 10 years. The problems have multiplied and the costs have gone up something like 400 percent.

MR. WILLIAMS: I have read some of these bills. The only thing they are talking about is cost. They haven't even touched on these other issues that you were talking about.

MR. CRAWFORD: The health security bill deals with a crisis as it affects costs and, most importantly, health services. It is the most humanitarian of bills. You have to deal with the cost issue, and I think it is unfortunate that that is given as much attention as it has been, because the important thing about this is people – people who cannot get into the health care system. I am sure, since you are in the field yourself, you come across these horror stories all the time of pregnant women being thrown out of emergency rooms because they haven't got the money to pay for the services, or they don't have private health insurance. Well, the important thing about health security is that it says money doesn't matter; you are entitled to health care as a right by virtue of your being a citizen of this country. Obviously you have to pay for it, and there is an elaborate financing system. But we don't mean to overemphasize that or neglect the important thing, which is a system that provides health care services to people.

MS. TYLER: How can we get copies of the health security bill?

MR. CRAWFORD: I am going to my office right after this, and I will bring you all copies. I will also get for you a comparative chart that shows the variety of national health insurance plans. There are five major bills, and two major concepts, publicly financed versus privately financed. The chart explains financing, health care benefits, services, administration, consumer representation, and all that.

MS. GIBSON: It seems to me that this group's recommendation is that the Kennedy bill best addresses the needs of the nation. Is that the recommendation? That is one of my questions. The other question: within the health security proposal, what parts of that proposal address training? Does it address how or who is going to be trained, and how to get more black people involved in training? I ask these questions because from what I have seen, none of the bills address training.

MR. CRAWFORD: There is one that does. Health Security does. We are going to have a special resources and development fund, and it has several purposes. First of all, it is going to build new health care facilities and clinics in areas where people are not currently served, in the inner cities or in rural areas. The fund will also be used for recruiting people. If you don't have enough black doctors or nurses or dentists, obviously there is something wrong there, and we are going to actively recruit among the minorities to get new health care professionals. This is crucial, we think, and we are attending to that problem.

MS. GIBSON: You say you are talking about the Health Security bill?

MR. CRAWFORD: Yes.

MS. GIBSON: It is not that clear in the bill. There is just one line in there, and it says "training." It is not clear; it is very brief, the training part, and this is what I am concerned about. Who is going to be trained? How is it going to be done? The answers to these questions are not clear to me, and I have studied the proposal intensively.

MR. FOX: I think that statement is very true. I don't think we can read through this summary and get the answers that we need to tell us the details of what is in these bills. It gives us a review of the various bills, but it does not give the information we would get if we had somebody from Health Security, National Health Service or somebody from the Ullman bill sitting down and explaining in detail what the bills do.

DR. DAVIS: I am Albert Davis, from Atlanta, Georgia. I have been dealing with health programs for a long time, and this conference became very attractive to me because the motive was black involvement in the federal government. Normally, I accuse myself as having very little involvement with federal government as a citizen, but when it comes to black involvement in federal programs, then all of us ought to know something about it. I have particularly noticed in the Congress that we have not dealt with the issue of black involvement. The biggest federal program now in health is the establishment of Health Service Agencies, HSA's, which we are all familiar with. The Planning Director, Dr. Cain, yesterday indicated that blacks were involved in the planning and advisory capacity in HSA's.

Now, those of you who are not familiar with HSA's, this is the carriage of medicine now. They tell you where you are going to practice medicine. They tell you what estimates you go by in the hospitals and whether or not you can expand a hospital.

In the southeastern part and the southwestern part of this country, blacks *are* on advisory committees. But this is not the important issue. The important issue is whether you are *planning* the program, *running* the program, and whether you are *directing* the program. If we, as blacks, are not involved in directing federal programs, if we don't get jobs as deputies or directors, or chief planners, or chief negotiators for contracts, then the black population will suffer for medical care. Because the big CAT scanners, the big equipment, will be located in predominantly white areas or in sophisticated medical centers that are far from rural and underprivileged areas. So, I think that in any health program minorities ought to be definitely involved in a specific manner. If we don't become involved in the administration and control of health care in significant positions, then we are going to lose as black providers as well as recipients.

MS. GIBSON: How can the general population or the black population have any influence on any of these health bills? As it stands, there are sponsors already for these bills, and I don't see how we are going to be able to influence the bills as they stand, or have any say-so at all. How would we start?

MR. CRAWFORD: Let me say this. We are actively seeking your involvement. That is why I am here today, to seek out your suggestions, to get to know you, see what your interests are, and what you want. No piece of legislation that is thrown in the hopper comes out the same as it went in, and the health security bill, I might add, is by no means fixed. We have regular meetings of our technical and executive staff to review suggestions. Now, I would like to build up a strong coalition with the black community to see what your health care needs are. If you feel that the health security bill is inadequate in any way, whether it is involving blacks in planning, administration, or control, we want to know, because this is not set in concrete by any means, and we are perfectly willing to make changes if you feel there are inadequacies. But you have got to realize this: ours is the only bill at present that attends to your interests at all. The private interest proposals leave blacks out entirely.

MR. WILLIAMS: Just because your proposal is the only one that attends to blacks, does that make it the right one?

MR. CRAWFORD: Well, I think there is no question that in the long run the Dellums health service concept will be the kind of program we are going to have, but that is at least 30 or 40 years away. We have got to build. The health security bill, in itself, should be regarded as a sort of incremental approach. I think in the long run we are going to have much stronger community involvement along the Dellums health service act lines. But you have got to realize that to get anything through Congress you have to begin somewhere, and the health security bill, I think, is the best beginning for all Americans, blacks included.

MR. FOX: It would almost appear, then, that this group does not have sufficient information to come up with a proposal, and I am not putting words in your mouths, other than that we need to have honest dialogue so that we can come up with a proposal. If the discussion to this point represents some kind of consensus on a proposal, it is for the group to make it. If you feel that you need more time to think this through, then that is also your privilege. So at this point can we decide whether to delay presenting a proposal, or should we just come up with the one that Dr. Holloman left with us, that we need to have honest debate with those people who are presenting proposals?

MR. DAVIS: What is wrong with the Dellums bill?

MR. FOX: In my book there is nothing wrong with it. This is for this group to decide.

MR. DAVIS: Can't we endorse it?

MS. GIBSON: Who are the sponsors of the Dellums bill? I have not seen that bill. I have seen most of the others.

MR. FOX: We might be able to find the names from someone here. Does anyone know, other than Dellums?

MR. CRAWFORD: Just Dellums.

MR. FOX: Dellums is only the congressional sponsor. Keep the discussion going; I will look through this listing and try to find the other names.

MS. WHEATELY: I agree that it would be a valid recommendation for this group to look carefully at the bills that are now before us. I also agree with Mr. Crawford, that we are not going to make a 40 year jump in six months.

MR. CRAWFORD: All I am saying is we have to be legislatively realistic. You don't want to throw the whole thing away because you can't get the one bill you want. You don't want things to go on the way they are now.

MS. WHEATELY: I think Ron Dellums told us that there is no way his bill is going to pass within the next 10 years.

MR. FOX: Our time is up for this session; it will be continued at 2:00 PM.

WORKSHOP I
AFTERNOON SESSION

MR. FOX: We can consider ourselves reconvened. There may be a bit of confusion as to what conclusions we have come to, and I am going to ask Archie, if you will, to bring us up to date.

MR. NICHOLS: From the session this morning, I believe we can say that it was agreed that there is a need for a national health insurance scheme in this country. The three key elements that the insurance program should have is that it should be: (1) comprehensive; (2) universally accessible; and (3) free of any deductible or coinsurance requirements. For our recommendations or proposals, we basically had three. The first was that we should recommend that a basic change be made in the traditional health care delivery system. We should recognize that there is a need for this change, and work toward securing this change and improving the quality of health at the same time. The second was that we should establish a data base which would enable us to make objective decisions on how to change the traditional health care delivery system so that we could actually improve health care to the black populations. The third recommendation was that black involvement in the actual planning of health care should take place not only at the initial planning stages, but at all levels.

MR. FOX: Now, you have heard what has been written down as what came out of our discussion. Please let me know what you think of these three recommendations. If there are additional ones, we certainly want to include them.

MR. CRAWFORD: This morning Mr. Williams brought up the point about our state of preparedness in adopting certain resolutions. I think if there is any question in anybody's mind about this, then we should consider establishing a further study group, and once again I am offering my services as a liaison for that, if you want further information. I would be only too happy to meet with you here in Washington, of if you are not too far away, I will come to you. But I think we should consider the importance of a thorough education on the issues before we say, all right, we are *gung ho* and we are going to do this. I know from experience in lobbying for the past few years, that it is more valuable to the Committee for National Health Insurance to have two people who are really commited to the issue and willing to work on it and devote their time to it, than to have 100 people who say, yes, well, I endorse your principles and then not do anything. So, I think before we really say definitely that this is what we resolve to do, we should make sure what our commitment is to it, whether we want to go on. Are you thoroughly happy

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with the resolutions so far? Or do you want to adopt them tentatively and go on to a study group?

MR. WICKHAM: I would have to go back. My impression of the resolutions at the earlier session was that basically we would try to find out how to get resources. The content of 57 bills is simply too much material. We could deal with maybe five of those bills here in this group.

MR. CRAWFORD: I think your point is well taken. Even if we had all the material here, there is no way in the world you could absorb all the information in even the five major bills in two days. I think what we should do is agree to further liaison and study on this. And if you will, since I am the lone representative here from one of the major groups, I will be glad to work with you.

DR. FOX: At lunch today, some people expressed to me that they thought they didn't have enough information at this time to come up with any definitive proposals, and that if it were possible to secure additional information, we should follow up this session with a subsequent session. And maybe then we could come up with some meaningful proposal.

MS. WHEATLEY: I agree with that. I come from California, and I would certainly like to take some of the data that I have acquired today back to some of the black groups that I deal with and have them deal with some of the issues and come back with some recommendations in writing.

DR. FOX: Since we have a representative from Expand here, and I am the leader for this group, perhaps this information could filter through Expand to the group.

MR. NICHOLS: In your information packet there is an address for Expand, and if you have any additional comments or suggestions for future meetings, you can contact us and we will be willing to work with you.

MR. CRAWFORD: We could also resolve on an educational drive, through distribution of literature and use of our speakers' bureau. The Committee for National Health Insurance would be more than willing to do that, to send you literature and speakers to each of your groups.

MS. WHEATLEY: I am a member of the board of the HSA in San Francisco, and I have never heard of this program.

DR. FOX: Well, we have a head start by having one representative here. I am sure Jim will get information – Jim, do you have all of these names?

MR. CRAWFORD: Yes.

MR. DULIN: I want to ask you what kind of timetable we are talking about?

DR. FOX: Tomorrow.

MR. DULIN: To get this information back to you or to Expand?

MR. CRAWFORD: Well, I am going to do mailings Monday to all the people that are here. We can get underway with this as soon as you like. If you have meetings, regular weekly or monthly meetings, we have speakers and a speakers' bureau that covers more than 40 states. If you have a large national convention, there is no reason in the world why we couldn't get some top name figures like Doug Fraser, head of the UAW and also head of our committee, E.G. Marshall, who is an actor and very well versed on this issue, to come to your meeting and speak to your people on it. And we also have audiovisual materials.

MR. SWIFT: I missed the morning meeting, but I have one thing to bring up now. I would like to see included in the list of resolutions the concept of public financing of the national health insurance plan. In the interest of black people in the country, any national health insurance plan advanced should be developed in such a way that it is publicly financed, as opposed to commercially financed, to remove the profit-making aspect from the system.

MS. WHEATLEY: Can Mr. Nichols read the recommendations one more time?

MR. FOX: Would you try it one more time?

MR. NICHOLS: It seems that we have basically concluded that there is a need for national health insurance; that it should be comprehensive, publicly financed, and be equally accessible to all segments of the population; that we should take a serious look at the traditional medical system with thought of reorganizing it and improving the delivery of health care, especially to minority populations. We decided that we do not have sufficient data upon which to make formal recommendations at this time; that a formal data base or an objective data base needs to be established; that we should look into the different means of establishing this data base, especially coordinating existing information.

We have stated that there should be black involvement in health planning at all levels; that we should have a follow-up to this meeting, so that after reviewing available data, individuals can make recommendations based on a review of the information as presented here, and that they will be able to derive from other sources. That is basically what we have at this time.

DR. FOX: Well, we heard today at lunch that those proceedings would be available in January. But that shouldn't stop you from securing additional information, writing suggestions to Expand, and writing suggestions to Mr. Crawford. I also have an announcement. A lady came in to me just a moment ago and said that when we reassemble, there will be a proposal that this conference consider supportive efforts to Meharry Medical College in raising funds. I would like you to think about it, so that you are prepared to say yea or nay to it when we reassemble. I certainly thank everyone for being here and for participating, and I know I certainly will be writing Jim myself for additional information. We do have meetings in New York, and I might be able to bring him up. Jim, do you have a closing statement?

MR. CRAWFORD: I just want to thank you very much. This is one of the most productive workshops I have ever attended. Thank you.

WORKSHOP II

COST CONTAINMENT STRATEGIES AND THEIR EFFECTS ON CURRENT PATTERNS OF HEALTH CARE DELIVERY

LEADER:

Gerald Rosenthal, Ph.D.
Director, National Center
for Health Services Research

FACILITATOR:

Richard Lowery
Expand Associates, Inc.

OBJECTIVES FOR WORKSHOP II

COST CONTAINMENT STRATEGIES AND THEIR EFFECTS ON CURRENT PATTERNS OF HEALTH CARE DELIVERY

This workshop focuses on the proposals before Congress dealing with cost containment issues in the health care sector of the American economy.

SPECIFIC OBJECTIVES

1. To analyze the various cost containment strategies that are being proposed by the Carter Administration (HR 6575) and other groups in the country (to include Senator Talmadge's bill on Medicaid-Medicare reimbursement containment strategies) - a financial and social analysis;

2. To determine who is to benefit from the enforcement of cost containment policies in the health care field, the provider or the consumer;

3. To analyze the effects of proposed cost containment policies on:

    - Municipal hospitals,
    - Other city hospitals, and
    - Rural hospitals;

4. To analyze and forecast the consequences of proposed cost containment strategies on the users of health care services in alternative patterns of health service delivery.

SUMMARY OF WORKSHOP II

"One person's cost containment is another person's unemployment." "If you can't make policy, say the hell with it and have nothing to do with it." "How do you press the health system to do the things it does in a less wasteful manner?" So it went in this most interesting workshop, devoted to the democratic administration's cost containment proposals and the impact of these proposed strategies on the health care of minorities, particularly black Americans.

The participants felt that cost containment may be the pre-game show for national health insurance. The public assumes that there is too much waste in the health system; the Institute of Medicine has reported there are over 100,000 empty hospital beds in this country – 100,000 beds that this country does not need, but tax dollars must support. President Carter's hospital cost containment approach proposes a 9% cap on in-patient revenues for certain hospitals. One participant made the following comment about this approach: "Unless any cost containment approach in the health system addresses itself to the practices of doctors, it is not going to contain anything." Although this group made some general recommendations, it primarily discussed, in a very conversational style, the issues associated with cost containment. The philosophy of cost containment, its short and long run effects and related economic, political and social issues were discussed.

The substitution of non-physician personnel in the medical care process and the use of home health care services are considered to be two mechanisms to rise in reducing the cost of hospital care and medical care in general.

WORKSHOP II

Cost Containment Strategies and Their Effects on Current Patterns of Health Care Delivery

Leader: Gerald Rosenthal, Ph.D., Director
National Center for Health Services Research

Facilitator: Richard Lowery, Expand Associates, Inc.

MR. LOWERY: Let me introduce Dr. Rosenthal, who is going to be the Workshop Moderator. I will wear two hats as the Recommendations Recorder and Facilitator. What I will do is call on people; I will try to make sure that everybody gets a chance to get in and I will do my best to be fair and impartial.

DR. ROSENTHAL: I had a button I was wearing yesterday; it said: "One Man's Cost Containment is Another Man's Unemployment," and underneath, in small print, it says "Federal Health Policy Strikes Again." I invented that button. It was probably a timely comment; it says what this workshop is all about. For every strategy of cost containment, there are 100 pieces of legislation. It would probably be much more useful for us to talk about the whole picture. Cost containment is becoming the main thrust of health policy. What are the implications of that? What strategies are to be used to effect cost containment? What are the possible positive and negative impacts of each of them? If we can agree on generalizations, we can move quickly to some kind of view as to some general classes of activities that are bad, and it seems to me that it might be more producive to deal with such questions than to dwell on the content of specific bills. Of course, the legislators are going to modify and compromise, and I think the trick is to come to some view as to what are the good ways and bad ways to attack the problem. Paul Cornely asked me how I was doing earlier, and I said, "When you are a person with positive objectives in a setting that has negative goals it is hard to do very well, but we are doing the best we can." And cost containment is a negative goal.

First of all, let me make one disclaimer. I don't know what the federal position is, I only know what my position is. That is really all I can speak to, and I have been doing that for a long time, and I guess I am going to keep doing that. Therefore, I can't tell you whether the view I have is widely shared, but it is an analytic view, because there is a certain logic to it that appeals to me. We produced a document – "we" being the National Center for Health Services Research – called *Controlling the Cost of Health Care.* In that document we tried to look at what research had been done that was useful to address the cost containment problem. I really felt that we couldn't send the document out without saying some things up front to put it into perspective. Essentially the argument summarizes in the following way: I talk about cost containment as a goal of public policy and health, and argue that that is really kind of dumb; because, if you look at most of the goals of public policy, such as access to care, or improvement of the health status of people, these are usually positive. But cost containment, as a goal, is negative, and is easy to achieve if that is really what you want to do. All you have to do is stop financing programs and stop paying for care, and the cost of health care will then go down. This a lot like the discussions we used to have about over-utilization. It was a big concern among hospital administrators a decade ago until we gave them a definitive solution to that. You merely close up all the hospitals, at which point you have no over-utilization. Of course, you also don't have any health care services. At that point it was clear that "over-utilization" wasn't really the problem. The real problem was the feeling that we could probably operate the system more efficiently with the same resources by being a little more careful about how we used it. That is a much different approach to the issue. With cost containment, the bottom line in the argment here is the line that says, "rather than being a central goal of health care policy, cost containment is a central constraint on the achievement of basic positive goals of public health care policy." In a sense, it is useful to remind people that that is the name of the game. It is always easy to spend less money on something, but in the process you often tend to compromise the reasons for doing it in the first place. So I thought it would be useful to pay a little bit of attention to that issue; how did we get in this mess? That establishes a useful context for further discussion.

First, a few generalizations. I believe that on the street there is a lot less concern with cost containment that there is within DHEW. I think that on the street, people are still concerned and telling their Congressman about the fact that they don't know how to get their aged parents in a nursing home; that they don't know how to find a physician; that the care they get is lousy. That is, it seems to me that people are still worrying about those things because while things are better for lots of people, they still aren't better for everybody; they aren't even good for some people, and they are horrible for others.

On the street people are much more cognizant of how health care impacts upon them. Nobody likes cost increases, and federal employees who, after all, are well provided for, become vocal when somebody cuts their benefits. When they cancelled mental health coverage in the Aetna plan last year some employees became very vocal but when the price of the Blue Cross plan went up $15.00 a month, they didn't seem to cry about that. So all this talk about cost makes me suspicious. I ask "why are they screaming about cost containment?" I have a theory that the reason people are arguing about the cost containment issue – the "people" meaning the Department, and some Congressmen – is that there is a great desire to move forward with some changes in the financing system, and everybody is afraid of what the cost of those changes will look like. So, as a matter of policy, they would like to pass a national health insurance bill. Responsible estimates of what it is going to cost run about $30 to $40 billion. So the trick is to get something in place called "cost containment," and then say we have dealt with that problem, and then turn our attention to national health insurance. That is a somewhat jaundiced view of the way the game is played. I talk to a lot of key Congressional staff and Congressmen who receive a lot of complaints that health care isn't that good, or that it is inaccessible. That is what people are worrying about. There is general concern with rising costs, but it is not really a political dynamic, so I have to look for some other reason, and I believe that political self-serving is part of it.

There are some facts: one, that the costs of medical care are rising faster than other costs in our society, and two, within medical care, the things that are most insured are rising the fastest. Any economist can tell you that is a reasonable kind of expectation. If I told you I would build a house for $25,000, I would build $25,000 worth of house. If I just said that I would build the house, you would take the best house you could get. There isn't anybody in this room who would not crack the $25,000 barrier. That is essentially the strategy that we have used in public health policy in this country. We started by providing services to children and mothers who were pregnant, and very quickly moved to a public strategy that says, "if you get it, we will pay for it." That is what financing strategies are. They leave the allocation, distribution, and production of resources to the marketplace. That has been the public policy, and it started from a logic that was absolutely unassailable as small logic, but it fell apart when it got to be a big program. The small logic was the following: out of all the things you do in a system, it is hospitalizations that cost a lot of money. But for the most part, people don't get to the hospital much. Remember we were having this discussion intellectually in the mid-twenties and mid-thirties, when, in fact, people didn't get to the hospital much. They went to the hospital to die or for very serious illnesses. There wasn't all that much they could do anyway. Somebody said, "There is a financing strategy. We will pick up that tab, that if, in fact, somebody falls apart and gets to the point where there is going to be a lot of financial burden, we will pay for it." In doing so, we changed the price structure without every paying attention to the fact that there are a lot of trade-offs and substitutes potentially available to people who are rational, responsible people. You know, if A is better than B, I would prefer A, but if A is better and a lot more expensive than B, you know, I might take B. A lot of us eat oatmeal instead of steak at one time or another in the world, and we make those judgments all the time. And, indeed, that was a responsible response. But it is a slow lesson in public policy. And, indeed, things are usually described as if everybody were nasty, rotten people trying to beat the system while, in fact, they are doing exactly what we told them to do. We said we would pay for hospitalization. Therefore, as a matter of public policy, we must believe that if somebody says you ought to be hospitalized, then that is good for you. That is what we tell people. The fact of the matter is that it begins to drive up the cost of producing in that end of the world, and it makes that setting where all of the rising capital costs show up, because that is the only part of the system that has got the money to support those costs. As we move to financing ambulatory care, on the grounds that it is cheaper than in-patient care, it doesn't remain cheaper very long. What happens is that we then see a rise in capital expenditures. We have CAT scanners in doctors' offices now, and those costs are going up. They are going up faster because the emphasis on ambulatory care brings new people into the system who wouldn't have been in the insitutions. So the evidence is that for every substitution of out-patient care, that you get by agreeing to fund it, you get 40 more people in out-patient care who wouldn't have been in in-patient care at all. Is that good for people? Well, it is good for some and bad for others. Is it more expensive? Of course it is. It costs more because we have agreed to pay for more. A doctor might say, "My malpractice insurance went up four times in the last two years, so let's run the CAT scan. It won't hurt the patient. The worse that can happen is that it costs a few more dollars. And if I get sued, I can say that I used the best and latest technology; that whatever went wrong was somebody else's fault." So costs are going up because we expect more; we have learned how to do more; we don't know how to say no in the system; and we are not sure we ought to. Now, when the thing gets too expensive, you have to ask what we mean by "too expensive." I know what "expensive" means; I don't know what "too" means in that context. Does it mean that the payers feel that they can't continue to cover the costs? That is a financing problem. Does it mean that society is dumping too many resources into that business relative to other things it ought to do? That is a resource allocation problem, and it is different from financing.

One of the reasons health care gets more dollars than, let's say, community development services, is that we have many more ways to get the dough into the health care system than we do in community health services. Let me give you an example. If you have a spinal cord injury and go to the hospital, and sit in the hospital for years, we can pay for that. It might happen that a little rehabilitation would let you walk around, but there are a lot of times we can't pay for that. Rehabilitation doesn't occur in hospitals and doctors' offices. So we have biased the system. We have done that without consciously deciding where we want to do it. People say that society has to decide how much it is going to allocate for health care. Forget it. There isn't anybody called society. The point is that after the fact we discover that the sum total of all the things we did ended up costing 8.7 percent of GNP (We estimate; we don't really know). Is this too much? Maybe it is not enough. I don't know what the answers are. But it seems to me that the dynamic is what are people worried about.

From a political standpoint, having all those funds show up in one program is bad for the things I do. I am a bureaucrat with a shrinking budget because something called Medicare and Medicaid is chewing up the entire Health Department budget every year, and there is nothing left for maternal and child health services. There is nothing left for the shameful job we do in half the Indian Health Service programs. There is nothing left for starving

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neighborhood health centers all over the country. That is a lousy trade-off in my view. On the other hand, one of the reasons the neighborhood health centers are starving is because we pay Medicaid bills too slowly, and maybe there is a way to deal with that situation in the context of the program.

I know that it is a complicated business, and I know that simplistic strategies are not going to do much more than stir up the pot and generate a whole new set of experiences. We have to generalize. We have to understand the general dynamic in this business; no Band-Aid is going to deal with the problem because there is no consensus on what the problem is. We don't know what "too much" is. We know we are spending a lot of money, and there are two feelings afoot which make us skeptical. One is the strong feeling that if we could look at the funding situations sensibly, we might still want to spend the same amount of money, but we would sure spend it in a different way. In some places it is too easy to dump more money into more tests. It is hard to dump money into preventive care. It is too easy to dump money into extended hospitalization. It is too hard, almost impossible, to get adequate prenatal nutrition. And yet, if it's health we are looking at, we would like to change that system somehow. No cost containment bill speaks to that problem. We have to understand that cost containment is the Band-Aid before the splint called financing strategy. We will go through our last gasp on that, and then we will turn our attention to whether or not people are getting healthier or less healthy, and then we will have to think about a health policy that deals with what is really important. Most of us got into this business for the positive delivery end of the game, and we don't like to see money rolling off in non-productive, incremental expenditures. But we don't know what to do about it; my guess is that the new health insurance bill and the cost containment bill are not where the solution lies.. I don't know where it does lie, but we will talk about the bills and some of their implications, or the kinds of bills, because it seems to me that they change by the hour.

MR. LOADHOLT: Doctor, my name is Herbert Loadholt. I am the Chairman of the Community Board of Greenpoint Hospital in Brooklyn. Isn't it monopoly on the part of the medical profession that causes prices to rise? Look at the American medical profession and the lobbies they have in Albany and Washington. Let's look at who we buy medicine from; a pill will cost the doctors ten dollars a thousand, and they will sell them for $10 apiece. Let's look at the duplicate services we have, the machinery that causes the city, state, and the community to buy services that they don't need. We have to bring it down to the people of the community to control their own destiny. Only when we start controlling our own destiny can we start to cut prices. We won't be buying five machines and putting four of them in the corner someplace to rot away. Let's look at multiple X-rays made of a patient when only one is needed. This costs us a tremendous amount of money. We have to start monitoring what doctors do, and bring doctors in who will look out for the interests of the people. We know that everybody from the top down gets a kickback. We are going to have to stop giving these kickbacks because it costs the community money. If we are to have an effective monitoring system, if an HSA is going to do this, and if that HSA pads the committees with doctors, we can never accomplish what we want to.

Let's look at Health and Hospitals Corporation. A man moves from HSA's top position to the top position in Health and Hospitals Corporation. This is a pattern that we have got to stop. This man is in the top position in Health and Hospitals, controlling that other top position he didn't resign from. He only took a leave of absence. When he gets everything set up the way he wants it in Health and Hospitals Corporation, then he will move back into the top position of HSA. So I am asking this body to come up with some kind of formula to stop these people from controlling our destinies. Otherwise, costs will always go up.

MR. DAVID SMITH: May I comment on that? My name is David Smith, and I am with the HSA in New York City. I am only going to rebut a couple of those points. Number one, the gentleman he said is now the head of the Health and Hospitals Corporation, Joseph Lynough, was nominated to be the President of that corporation, and will probably become President of that corporation. We at HSA expect that he will not be back. The gentleman who is running the HSA now, Mr. Anthony Watson, we hope will continue to run it, and I, for one, can tell you that Joe is not telling Tony what to do. Your comments raised the point that I wanted to bring up. We can't have cost containment by legislation; legislation is an ineffective tool. We are not going to get cost containment from any of the bills that are presently in the Congress. Historically, all the bills that have come out of the Congress concerning the delivery of health care have produced problems that the Congress did not anticipate; that the country did not anticipate, that led directly to the problems that our good friend from Greenpoint talked about.

As I look at it, nobody knows if we are spending enough or spending too much because nobody has defined need. But there is another problem. That problem is that the cost of health care comes out of everybody's pocket; all of us are spending a tremendous amount of money to support that industry. Therefore, we need to look at it and see how effective are those dollars we are spending. Are people in better health today than they were five years ago? Are we getting better health care because people get a CAT scan? Could we get along with fewer scanners? We tried to address this problem in New York City by saying that there was only a need in New York City for 30 some-odd CAT scanners.

DR. ROSENTHAL: Just three would be enough.

MR. DAVID SMITH: Yes, three would probably do it, that's right. I think they have three in the whole country of Sweden. But we said 33 in New York City. The reason was that University Hospital already had 16, but they were all in Manhattan, and we had to give some to Staten Island, Queens, Bronx, and Brooklyn. So the gentleman's point from Greenpoint is right on, I think, and that is that we have got too much machinery or too much light cost technology. People like me, who came into the system as a consumer in '72, think that we are watching the biggest rip-off of all times.

MR. MIRACH: My name is Harry Mirach. I am from the University of Pennsylvania at Philadelphia. I would like to ask Dr. Rosenthal if he could get back into the financial and social analysis of the cost containment bills that are being presented in Washington, so that we can discuss some things which will affect us all, all over the country, as opposed to dealing with one particular city's problems.

DR. ROSENTHAL: Yes, I think I need to do that by integrating these observations into the comments that I was making. I was not talking about a nonsystem. We have a totally responsive, perfectly logical and reasonable system, except that there are a million different influences on it, and that is more than we can figure out the net result of. So our national policy has become "when in doubt, add it to the system."

By the way, there is no evidence that giving the people a larger voice in the system would result in less technology. There is plenty of evidence that there would be a lot more. Try and close a hospital in the City of New York that you don't need, and see what the people want. They are not interested in saving the cost. They want the hospital up the block. They are just like the people in Seattle, Peoria, or any other city or town in the United States. I was in Southern Wisconsin yesterday, and the *Mountain News* had a big article on rural hospitals, six beds, eight beds, ten beds. It is entitled "You Won't Miss Them Until They Are Gone." They want more money and more technology. The people want it. There is no doctor. They want to get a doctor to come in there and use the technology they want. A few years ago a kid got his arm torn off and some doctors sewed the arm back on. It got TV coverage, and within a day thousands and thousands of people showed up at hospitals all over America with fingers, toes, arms, and legs demanding to have them sewn back on. We didn't really know how to do that; we didn't even know whether the kid was going to live, and it took 50 people working on him for half a day to do it. But telling people those hard facts didn't make any difference.

So we have got a set of expectations; the dynamic is clearly there, and the financing strategies have all been designed. The second point you made is that legislation to date has primarily been targeted at some delivery performance function, and it has been more or less successful, but the cost impacts have always been underestimated in the political process. You can't pass a bill when people know it is going to cost $20 billion. We would never have had a Medicaid program if there had been an honest assessment of what it would cost. There were some honest assessments, but Congress really wanted to pass that bill, and my guess is that most people in this room figured it was a good deal. We would still be sitting around with folks dropping over like flies if Medicaid were not in place.

The problems we have are the problems of a program that is big and complicated, underfunded, undersupported, and badly administered. But considering that there are 200 people in Washington and 29 people in the entire State of Massachusetts managing a billion dollars' worth of that program, no wonder it is terribly run. I mean the feds said the states were going to manage it so we won't need to hire people to do it, and every state said we don't have the people to do it and the feds will have to do it. The net result is that nobody does it, but the money keeps flowing through.

Now did it get ripped off by people? No. Did it get ripped off by providers? Somewhat. But in most cases, considering the scale of the program, Medicaid delivered the goods. Now we are worried about the cost. So what I am saying is that the cost containment mentality has slowly come to us. And one of the strategies has been to limit eligibility. That is, for the people in the game you can't change the game, but we are going to leave some people out. Another strategy really is to compromise the set contingencies covered by the program. We have long discussions about what treatments should or should not be covered. For example, an 80-year-old woman falls down and breaks her hip. They do hip joint replacement. A lot of people say that is a terrible thing. It is a waste of money. But you know, the lady broke her hip; it would not be fixed any other way. She is walking around instead of lying in bed vegetating. Then there is the kidney dialysis problem. The same Congress that heard that 400,000 kids a year were mentally retarded because of poor nutrition, also heard that 3,500 people a year die from end-stage uremic failure, and agreed to spend what is going to be next year probably a billion dollars in providing renal dialysis for these people. That happened because they could see the kidney victims; they were visible, and you knew who they were, they were going to die. There wasn't any ambiguity about that. The undernourished kids are most invisible, so Congress went for acute care services and gave no thought to cost containment. There are tremendous political pressures not to deal with ambiguous situations, and tremendously insufficient medical information. So we don't know what to leave out, or even really how to have a sensible discussion of the issue.

MS. WILLIAMS: Not to belabor the point, but I would like to hear some discussion about strategies for hospitals who have large Medicaid populations.

DR. ROSENTHAL: When I get to that particular problem, I will certainly address the issue of cost containment and its impact on those institutions.

MS. CUFFEE: I am Lola Cuffee from Brooklyn. I am a member of the HSA. I am very interested in people in the gray area, who are not eligible for Medicaid or Medicare. I think it is very essential that something be arranged so that they can get care when they need it. In Brooklyn we are swamped with people who can't get medical care. And the state has started a new program; if you have a Medicaid card, it has to be renewed every 30 days. Look at the paperwork. Where are they saving money?

DR. ROSENTHAL: Well, that is another way of limiting eligibility. Limiting the benefits is another program strategy. When you get to the total costs, however, neither of these accomplishes anything. Now, the third kind of major strategy is a throw-up-your-hands cost containment strategy that deals only with aggregate dollars. They place a cost ceiling (cap) on revenues flowing into the institutions. It is usually targeted on individual providers but need not be. They are talking about doing it at the HSA level for capital investment. That is to say that you get $4 1/2 billion worth of capital investment next year for the country, as a whole, and your area has $26 million, and that's it. You guys figure out what to do with it, but I know that the total is only going to come to 26 million. Now, how successful can cap strategies be in terms of limiting total expenditures? It depends on how you describe the cap. It depends on how you monitor conformity, and it depends on how you evaluate future payouts for current expenditures. So even a simple strategy is complicated. But the basic cap strategy says you are an institution, you can only have a nine percent increase in your revenues this year. The cap strategy puts the burden of deciding what gets left out and what gets done on the individual institution, and that is the President's game.

MS. DADE: In regards to caps, where is that being proposed? I wonder if there is any articulation between collaborating forces, between accrediting agencies and HEW in the context of those deficiences? The accrediting agencies make proposals to institutions for updating facilities. They have codes that institutions must meet. But there is a cost containment cap, which means that institutions cannot spend in excess of X number of dollars to bring their facilities up to standard. There needs to be some meeting of the minds someplace so that an institution can remain viable, give quality care, and meet basic and minimal needs.

DR. ROSENTHAL: A good cap arguer would say that you have to meet those standards and leave something else out. So if you are an institution with a lot of fat in your budget you can survive. But if you are an institution that has been running on a lean budget, and doing a good job in minimizing excess expenditures, you are going to get stuck. That was clearly the experience that we found in the economic stabilization program. The exception requests came from the most efficient organizations, because they didn't have any slack in the amount of money they were spending; they didn't have much they would leave out. It is the old neighborhood health center business all over again. I don't know how many of you had experience in that, but when HEW finally set rates for visits, they didn't add the outreach services, and they didn't add the counseling services, and they didn't dare add the day care services. They didn't add all of the things that made the center a viable source of health care in the community. What they did was pay for the same care components you used to get from the hospital outpatient department, and that wasn't an adequate rate to support the services. The argument of a cap strategy is that you put the burden on the system or institution to decide how the allocation decision gets made. If an institution can't get up to code, as they put it, then it has got to go out of business, or it has got to ask for an exception, and the exception process is what we have relied on to prevent the disasters.

MS. DADE: That is my concern because it seems that we are in an endless spiral here. We are forever chasing our tails. We are making a profound effort now to provide accessible care to those people who need it most, and the Cost Containment Act seems to be fostering what we are trying not to do.

DR. ROSENTHAL: Cost containment strategies are all designed to reduce the flow of dollars into the health care system. And the issue we are discussing is simply this: do some strategies for cost containment make it harder to do the job than others? Remember when you are talking cost containment we are talking negative goals; we are not talking about positive achievement. The perfect cost containment program is the one that at least compromises the achievement of the basic objectives of the health care system. Now in your heart, you know that if you took the garbage out of the system, there would be plenty of money to achieve the basic objectives. But they are not going to do it; they aren't going to reduce those "extraneous expenditures."

MR. LOADHOLT: Who is "they" you are talking about?

DR. ROSENTHAL: That is the question.

MR. LOADHOLT: Your discussion up to now has left me confused. We are spending billions and billions of dollars but no monitoring system has been set up to help us know where this money is going. Let's come with a monitoring system, with Blacks and minorities participating on the top level, so that they can be in a position to know what is happening. You have been giving us a lot of rhetoric we don't understand; we have to start understanding what you are talking about.

DR. ROSENTHAL: That is right.

MR. LOADHOLT: I am only being frank because I am tired of being ripped off by the medical profession, and the medical professsion is the one that is ripping the people off. You are a doctor, and I have got to hit you in the pocketbook. I am not an enemy of doctors, but I am not in love with them either, because they are killers of poor people. So let's get down to facts, and try to set up some type of forum to watch our pennies and dollars.

MR. MIRACH: My name is Harry Mirach, from Philadelphia. I want to get an idea about what you mean when you say there is enough garbage in the system to help improve it if those resources were redirected toward things that would really work. And I want to know how the cost containment strategy proposed by the Carter administration will help to do that.

DR. ROSENTHAL: Well, the second part first. It is not clear that the administration's proposal will help. That is the point I make. I am not making complicated points because I don't think it is a complicated problem. I think the solutions tend to be quite elaborate and complicated because nobody is prepared to agree on the criteria for making choices. So we look for a process that puts the choices on somebody else. The cap strategy says "these are the amounts of dollars coming in, and you guys figure out how to deal with it." Now, what I am hearing from my friend in Brooklyn is that there ought to be a way of putting the criteria up front and making the decisions in a different way. I am telling you that there is no good recommendation as to how to do that. And this is something we should address.

MR. MIRACH: But if the cap strategy is giving the money to the least efficient run hospitals, then you are contributing to inefficiency.

DR. ROSENTHAL: No, you don't understand. If I run an outfit that is getting cost reimbursed and I have a lot of junk in it that I could live without and still do my job, when they put the squeeze on me for costs, I can leave some things out.

It isn't really, clear, though, that people are leaving out the things that are most readily left out; what I am saying is that positive issues of who is getting what are not really addressed in the cap strategy. The cap strategy only addresses total amounts. It says I need some assurance that the health bill isn't going to be more that $427 billion this year, and that is what I am going to put into the system, and you guys work it out. In an institution that has a lot of community involvement, they will work it out with the community. In an institution that sits aloof from the community, they will continue to do the CAT scans, and they will leave out the ambulatory child care clinic. But you are asking me how the cost containment business works, and I need to tell you that ultimately it is quite simple. The cheapest system is one where you don't pay for anything.

MR. ORR: My name is Harold Orr. I am a doctor practicing in California, and I am one against this whole cost containment movement. When you talk about cap, aren't you talking about federal dollars only?

DR. ROSENTHAL: Not necessarily.

DR. ORR: The cost containment program is an institutional revenue cap. It doesn't make any difference where the revenue comes from.

DR. ORR: Does it effect the private dollar of an affluent individual who can walk into a hospital or a doctor's office and pay for whatever services he or she needs? How can that revenue source be controlled? Can the profit motive in health care be removed? Until that is done, everything we do is just tangential to the problem.

MR. LOWERY: Dr. Haughton?

DR. HAUGHTON: I think we are ignoring the real problem. Jerry talked about all the garbage in the system. In Chicago they are saying that there are 4,000 unnecessary hospital beds. We are all paying for them. I went to San Francisco a few years ago for HEW, when they were trying to give away the Public Health Service Hospitals, and I found 1,500 new, unused beds in the Bay area. That is what Jerry means when he talks about garbage in the system. We have got to shrink the system. The Institute of Medicine has just reported that there are 100,000 empty hospital beds in this country. Those are 100,000 beds we don't need. We are all paying for them. The planning process has got to be able to look at that surplus and say to an institution: "You must close down this facility." Dr. Cain talked yesterday about health planning standards, and he said any hospital that has less than 2,000 deliveries a year should close its OB Department. In Chicago recently our HSA said that any hospital involved in open heart surgery, that is doing less than 200 cases a year, should close that program. They are absolutely right. You have got to shrink the system; there is no way around it.

Now, this cap business assumes that hospital directors dictate what happens in hospitals. Nothing is further from the truth. I run a system with 3,000 beds, and it is the doctors who decide what happens in those hospitals, because they are the ones who write orders for the patients. My jobs is to see that they have the things they need to take care of the patients. Even though I am a physician, I am not out there telling doctors what to do. Doctors write the orders, and if they write orders for $2,000 worth of work to raise the accuracy of a diagnosis from 95 percent to 97 percent, and I say that is a waste of resource, they say I am interfering in the practice of medicine. So unless any cost containment approach in the health system addresses itself to the practices of doctors, it is not going to contain anything. Already, in Chicago, just from the threat of a cap, our high-risk pregnancy admissions went up 42 percent over the last six months. Why? Because high-risk pregnancies are costly cases. The mother stays more than the usual four days, and the baby may stay three months. Hospitals threatened with reductions in their revenues don't want those cases. In just six months at Cook County Hospital, our high-risk pregnancy admissions went up 42 percent. That is the kind of thing that this cost containment business is going to have to address.

DR. ORR: Is that profit motivation?

DR. HAUGHTON: That has got nothing to do with profit. It has got to do with the fact that if hospitals are required to reduce revenues – not expenses, but revenues – they will not accept revenue – producing cases because they will hurt them in the long run. It seems odd. It doesn't sound economical at all, but that is the fact. Take burn cases, for example. We have a large burn unit in Chicago. There are a few university hospitals that sometimes accept burn cases. They will no longer do that because burn cases that generate revenues will put them in trouble with their revenue cap. That is how it is going to foul up the system.

DR. ORR: But financially received dollars can't possibly affect privately given dollars.

DR. HAUGHTON: A cap affects every dollar that shows up on the balance sheet. It doesn't matter if you went out and got it from philanthropy. The cap policy says you must reduce your revenues. It doesn't matter where the money comes from.

MR. COLLINS: Tom Collins, Washington, D.C. We have a love-hate relationship here. It is coming down to the doctors who make the decisions about what he does to expand the cost of medical care. A lot of times we, as consumers, never question a medical procedure. It comes down to that, also. It also gets back to educating our doctors about what is economically feasible. The medical schools across the country teach physicians how to take care of us, don't teach them how to take care of us in an economical manner, and we, as consumers, have to begin to demand that from our system. The question I have in the whole cap business is that, in low income areas where the hospitals sometimes provide the only place of employment for nonskilled worers, how do we work this out if they are closing 2,000 beds? That is putting nurses, interns, and orderlies, out of work. We, in the community, are supposed to provide not only care, but jobs. How do we address that problem? It seems a difficult question to answer.

DR. HAUGHTON: It is not a difficult question to answer at all. Somebody has already said, a young economist, that one man's cost containment is another man's unemployment.

DR. ROSENTHAL: Thank you. I appreciate that very much.

MR. LOWERY: In the interest of time, we are going to have to break now for lunch.

WORKSHOP II

AFTERNOON SESSION

MR. LOWERY: Okay. Why don't we get started. The purpose of this afternoon's session is to come up with specific recommendations that can serve as the product of this workshop, which, when put together with the product of the other workshops, can be submitted to federal policymakers as recommendations from this conference. What this requires is that we now start thinking in terms of the specific things that you believe must be done, particularly those kinds of things that transcend the concerns of one institution. We should be producing recommendations that would provide benefits to more than just one institution or one person. So why don't we just pick up from where we left off before?

MS. BENNETT: My name is Allison Bennett. I am a private consultant, with my own company, Allison M. Bennett Associates, in Brooklyn. I would like to comment about the providers of services with regard to cost efficiency. We know that salaries are one of the greatest cost items in any budget, yet we are not using all health care professionals as efficiently as we should, and I speak particularly of nurses. There have been millions of dollars poured into nursing education over the years. But, the medical profession works very hard to ensure that nurses do not utilize all the skills they can bring to the health care arena. One way that we could reduce costs is by having many of the duties that are carried out by the physician assigned to the nurse. The cost of a service provided by a nurse is only a fraction of the cost of that same service provided by a doctor. In New York we have something called the Nurse Practice Act, which doctors have worked vigorously to oppose, which allows nurses to practice independently.

MR. LOWERY: Could you structure your recommendation for us?

MS. BENNETT: I hope there might be more comment before it becomes structured.

MS. REESE: Are you talking about nurse practitioners?

MS. BENNETT: I think we can call them whatever we want. I hope we will not be caught up in a title. Nurses can do physical assessments, make certain judgements, refer patients, and collaborate with other health care professionals. They are taught and trained to do these things. Yet, we find, in most institutions, nurses doing clerical work. They are working as clerks after millions of dollars have been poured into their educations.

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MS. SMITH: I am Margaret Smith, from HEW, San Francisco. I would like to add to what she is saying about nurses. You don't even have to talk about nurse practitioners doing health assessments. You can talk about utilizing nursing skills for health education and instruction to patients. This is discouraged, in the clinical setting, so that nurses eventually lose those skills. Nurses are an asset that should be used.

DR. ROSENTHAL: Is there anything in the rules of the game, that you could change, that would make that more likely to happen? We are talking about telling the feds what to do, and they don't really deal directly with professional job assignments within institutions.

MS. BENNETT: One of the things we have to look at is the amount of time allocated to each patient. A doctor is allocated X number of minutes for X number of physical exams. Nowhere in that formula is there time for health education, which is what you are speaking to. The formula has to be changed so that education can take place, and it need not be education by the doctor.

MS. SMITH: I also believe in paying for it. If we decided we were going to pay for it, it would be done.

DR. ROSENTHAL: Do you see that as a cost containment strategy?

MS. MARGARET SMITH: I do, because what you do is reduce physician's services.

MS. REESE: You might also reduce the numbers of times patients would come back with repeated problems if we had the health education. So that certainly is cost containment.

MR. LOADHOLT: We find in setting up outreach programs to get to the community, that in order for reimbursement to be made, you must have a doctor on the premises. But the nurses actually do all of the work. A lot of times the doctor is getting paid for just sitting. There are lots of places where physicians could be eliminated and nurses could take over. But new legislation would be required to put nurses into the reimbursable provider category.

DR. WILLIAMS: I am Dr. Graeme Williams. I am a little afraid to say I am a doctor after all the darts that have been thrown at doctors. I am the Assistant Medical Director at Martin Luther King Hospital in Los Angeles, as well as an elected member of the

Board of Directors of the Los Angeles HSA. I would like to redirect the workshop to the objectives. I am interested in Number 3. I would like to pose a question to Dr. Rosenthal. How do we make sure that the effects of cost containment policies on the private sector do not shift the burden of medical care to the public sector?

MR. LOWERY: This is a major issue. If you have some thoughts as to a recommendation, that would be useful, and then others could perhaps follow it. I think this group needs very much to articulate specifically the precautions that ought to be paramount in the pursuit of cost containment. Here the question raised is a sensitizing one. What happens when the squeeze is on in Medicaid and the municipal hospital gets bombed? Jim Haughton's critical pregnancy cases go up and up and up, and all of the severe burn cases show up in Cook County Hospital, because the rest of the guys having decided they don't want to play that game. Do you want to have a cost containment policy that doesn't allow people to change their case mix? That is one approach. If they change the mix, lower the cap, and take the difference and put it directly in the municipal hospital's budget. Skimming can be to your advantage or disadvantage depending on how the rules are working. We are talking about those rules.

DR. WILLIAMS: One way of preventing this transfer of caseload would be to make financial remuneration to the private sector more attractive, but that is going to increase costs.

MS. SMITH: I am not an expert in this area but it seems to me that there should be a way to provide a financial incentive to take care of the poor in a cost containment strategy. Rather than paying, say 80 percent of the usual and customary fee, you should pay 105 percent to take care of the poor. We could set up guidelines for that.

MR. BOTT: Was utilization review ever brought up?

DR. ROSENTHAL: Only obliquely.

MR. BOTT: I think that is something that should be a part of every cost containment program.

MS. GAMMONS: My name is Joan Gammons, from Los Angeles. Looking at Question 4, talking about outreach, it seems to me that by increasing your outreach programs, you really aren't going to do anything in terms of cost containment; those programs will increase your costs. If we have to cut costs, if we have to curtail our expenditures and our revenues, what are we going to do? Outreach is not really an answer. It is just another service that we provide to get more people into the hospital, which we don't really want if we can't increase our revenues.

MS. ATKINSON: The impression I get is that we are thinking in terms of physicians fees as the heart of the cost containment issue. But that really isn't the situation. It is the auxiliary services that are pushing up health care costs, rather than fees to physicians. Outreach programs can contribute cost containment because they decrease the number of individuals utilizing hospital facilities.

MR. WARE: Gary Ware. I would like to respond to that. One of the major issues in cost containment legislation is the extent to which lower level employees were going to be exempt, and we all know who the lower level hospital employees are. To say they are the major reason for increased costs is to do us some injustice. Now it may be true that what shows up on a hospital bill is not physician costs, but it is also not the wages paid to lower level employees.

MS. ATKINSON: No, I don't remember saying anything about wages paid to lower level employees. I indicated auxiliary services, and by that I am referring to the cost of the room itself, the cost of clinical laboratory procedures, and the cost of X-ray procedures. Many hospitals have expensive scanning equipment that is utilized routinely only because it is there. These expenses are enormous.

MR. WARE: And those auxiliary services, with their "enormous" expenses, are staffed by allied health personnel who are at the lower levels in the hospital hierarchy.

MS. ATKINSON: What you consider lower level would be upper level for the average black person in the street, whose income is $3,000 or $4,000 a year, compared to $12,000 and up for allied health personnel.

MS. MARGARET SMITH: For some time now we have worked in the field to provide alternate and multiple services to our people, because they have had a greater incidence of chronic disease. I would hate to see those services done away with because they are considered to be expensive, add-on kinds of things. In the long run, the best cost containment strategy is to produce healthier people who need fewer hospital services.

MS. ATKINSON: That is addressing the issue. It takes the discussion away from singling out a particular group and makes a statement based on reality. If cost containment is directed at one specific provider group, it won't work. What works is to evaluate programs and services in terms of end results.

MR. LOADHOLT: The government is going to spend about 150 billion dollars on health this year. Some of that money should be used to deal with what causes a person to get sick and need service in the first place. Those causes are many, but most of them are in to become ill. During the cold winter months when poor people don't have heat in their homes, kids get colds and pneumonia, and eventually go to the hospital. Then it costs the government $10,000 per child. It would be better to take $5 billion out of $150 billion and build some decent housing. Then we would be doing something to cut down health care costs.

DR. WILLIAMS: I would like to make a definite suggestion. In the discussion yesterday and today, it was brought out that one way of cutting costs is through prepaid health plans and HMOs. The problem with HMOs and prepaid health plans is that they cannot get their patients admitted to hospitals. And, as you know, the only way that HMOs and prepaid health plans save money is by taking advantage of under-utilized facilities, and by treating people as outpatients rather than inpatients. I would like to suggest that the Federal Government come up with a formula whereby hospitals that have a bed occupancy rate below 80 percent be required to allocate a certain number of beds to prepaid health plan and HMO patients.

MS. ANN SMITH: Is it appropriate to speak to the cost containment standards that were published?

MR. LOWERY: Sure.

MS. ANN SMITH: We have looked at the standards, and feel that, except for the first two, they are for the benefit of large, established, academic institutions, and will have a negative impact on the consumer, particularly the low income and minority consumer. Requirements such as a minimum of 2,000 deliveries to keep the maternity ward open, or that a minimum number of heart procedures must be performed to stay in that field mean that doctors who own hospitals will start prescribing and performing heart surgery where they used to do referrals for heart surgery, and will try to increase the length of stay to get occupancy rates up. Those rules are going to raise costs and not contain costs. Smaller hospitals that serve the areas just outside the city, but not in a rural area, will close, and poor people, especially minority poor people, will have a worse problem of access and waiting time.

MS. GAMMONS: In terms of cost containment, it would seem that if a hospital did contract beds out to an HMO, that they would be increasing their revenue. But the hospital should not be penalized for that. That increase should not be counted in the nine percent maximum.

MR. REESE: I am concerned with the Certificate of Need regulations, which eliminate any requirement to review the situation when a hospital decides to close. There is a provision for review of modernization, increased capacity, and replacement of the new site. But in many urban areas the hospital serving the minority community is closing.

DR. ROSENTHAL: There are, however, lots of state planning requirements that both closures and modifications have to be approved by the local planning agency. I know Maryland has such a rule.

MS. REESE: California does not have such a rule.

MS. MARGARET SMITH: The problem is that if the feds don't set it as a minimum, the states will not do it, as California did not, and as most states did not.

MR. SWIFT: Gary Swift, Howard University Hospital. I have a comment that I want to make as an administrator of a hospital. I am of the firm belief that it is impossible to establish standards to apply to all hospitals across the country, because different hospitals in different operating environments have different types of populations. I believe very strongly that there should be flexibility in the standards. For example, at Howard University Hospital, 35 percent of our in-patient load consists of people who do not have the resources to pay for their care. We operate in a deprived area. We have a heavy caseload in our emergency room, and as most people in the health field know, emergency care is very costly. I would suggest that whoever is responsible for making amendments to the regulations address that issue, and establish some exemptions to deal with those hospitals that are faced with unusual circumstances.

MS. ANN SMITH: I would like to follow up on that a little bit. I work for an HSA, and we can't get data from either the hospitals or other federally and state-funded agencies to make the kinds of decisions that are mandated under the cost containment policies. Those policies must contain requirements for sharing data among agencies and institutions.

MR. SWIFT: Another point --

DR. ROSENTHAL: Is this the same issue?

MR. SWIFT: My comment dovetails with what the young lady just said, in terms of regulations that we have to comply with at the hospital. The Joint Commission on Accreditation for Hospitals is constantly coming out with new regulations that require structural changes in our hospital. Then we have to comply with the regulations of the local regulatory agency, and to do that we have to spend money, and a 9 percent annual revenue increase is too tight a constraint to put on a hospital.

DR. ROSENTHAL: Well, I think the problem is well articulated, but not solvable in this room. It is also a lot more complicated, unfortunately, than it ought to be. The issues you raise link to a bunch of other things we have talked about. Remember that cost containment is year to year, and it says you squeeze this year. Some people are able to do that better than others; they may not have done as good a job of using their resources as they might have, so it is easier for them to accommodate. The problem comes from a sense of frustration that there is no way to be sure that gentle exceptions or flexible strategy will not be utilized to exploit the program and defeat its objectives. The rule among regulators is that you have to change the rules at least every six to eight months, because it will only take that long for somebody to figure out how to subvert the rules and do what they were going to do anyway in the context of your rules. And that necessity for rigidity runs directly counter to the desire for an ability to respond locally, an ability to deal with community realities.

Cost containment also ignores the fact that some of the products of in-patient institutions, particularly in low income areas, are outreach - out-patient kinds of services that don't show up on that little list of things that the money is supposed to go to. One of the things that you might want to suggest is to treat those separately, to have the resources required to support those services not laid off against the revenue cap.

MS. MARGARET SMITH: Has anybody spoken to home care as an alternative? I'd like to make a pitch for that as a recommendation out of this group. The government does not pay for home care the way it should. We need home care or intermediate care for the chronically ill, and for those who can be maintained outside of hospitals and long-term care institutions. It is also necessary to set up standards for home care agencies, so that we don't just get an expensive housekeeping service. I'm talking about quality oriented home health care, and I think it's a very cost effective thing and it is about time we did something about it.

MS. MARGARET SMITH: I have one other thing. When the Administration puts together its cost containment policy, there is no reason in the world why there can't be an advisory committee set up to monitor whether the policies that are being developed deal with access and quality issues. I would like to put that forward as a recommendation.

DR. ROSENTHAL: That is essentially the view of the comments on the bill that was developed out of the Public Health Service, that they are not in business to limit expenditures but to improve health. I said earlier that I thought a lot of the interest in cost containment comes from a relief that it must be dealt with before moving on to other financing strategies.

MS. CUFFEE: We should be policymakers instead of recommendation people. You can recommend anything, but it doesn't mean a thing without real policy-making power to go with the recommendation. I refuse to sit on any board in my community to make recommendations. If I can't make policy, I tell them good-bye, because I'm too old to be sitting on boards recommending things that don't get done. Black people should stop serving on advisory boards. Make policy. If you can't make policy, then have nothing to do with it.

MS. ANN SMITH: Supposedly, the health care industry is going to become more capital intensive instead of labor intensive. If that's true, we have to deal with new technology in cost containment strategies. Any cost containment strategy should deal with all forms of technology. Maybe they should have to keep a piece of equipment and use it for three years before they could buy another piece of equipment from the next generation up. That's one of the things that's raising costs terribly high; there should be a general new technology criterion.

DR. ROSENTHAL: Well, the simplistic cost containment strategy says that if an institution wants to buy a new piece of equipment every six weeks, they're not going to find the money. What the people in this room are saying is they know what's going to happen; the hospital will buy that equipment anyway.

So what we need is a cost containment strategy that changes the priorities, and the resource allocation to produce improved service. The trick is to decide what you're prepared to allow them to consider leaving out, and we've spoken to that in a lot of ways today. On that note, I do think that we have to bring this meeting to a close so that we can reconvene.

WORKSHOP III

EFFECTING HEALTH PLANNING STRATEGIES IN THE BLACK COMMUNITY

LEADER:

Fred Adams, D.D.S.
Chairman, Connecticut
Health Planning Agency

FACILITATOR:

Steve Wilson
Lowndes County (Alabama)
Health Services Association

OBJECTIVES FOR WORKSHOP III

EFFECTING HEALTH PLANNING STRATEGIES IN THE BLACK COMMUNITY

The health planning and resources development act of 1974 (PL 93-641) has been viewed as a major mechanism for improving the planning process and reducing excessive costs in allocating scarce health resources. Has it, or should we expect it to?

SPECIFIC OBJECTIVES

1. To define health planning in an operative framework for discussion purposes;
2. To provide an up-to-date overview of the status of health planning as a national health policy strategy;
3. To determine the extent and nature of the involvement of representatives of the black community in the health planning process - local, regional, state, and national;
4. To determine strategies the black community can utilize to ensure a better distribution and allocation of health resources, i.e., what can the black community do to secure physicians, dentists, health facilities, and health education activities in their communities for their tax dollars, and what can they do to prevent the loss of existing resources?

SUMMARY OF WORKSHOP III

This was one of the more interesting workshops of the conference. Dr. Adams began the session by providing an excellent summary review of the historical development leading to adoption of PL 93-641, beginning with the Hill - Burton Legislation of 1946. He also provided some insight into the political maneuvering necessary to become chairman of a state SHCC, and of the political pressures one must face in the health planning process.

The essence of the dialogue of the workshop proceeding can be summed up in the following general recommendations.

(1) That there be seven amendments to Public Law 93-641. These seven amendments would allow consumers to have legal and persuasive authority to control health planning policies in their service areas;

- (a) Redefine the term "representative" more broadly to relate to the social, racial, linguistic, economic, makeup of HSAs;
- (b) Revise the law to ensure representation from a broader range of health manpower, other than physicians and nurses, dentists and optometrists, and to specify inclusion of physician assistants, nurse practitioners, and allied health professions;
- (c) Assure that minority providers in all categories are represented on the HSA board;
- (d) Encourage the employers of consumers to grant leave with pay in order to attend HSA and SHCC board meetings;
- (e) Reimburse board members for certain out-of-pocket expenses, such as babysitting expenses, when attending HSA meetings;
- (f) Limit the power of providers on HSA boards; and
- (g) Develop a mechanism to ensure and enforce affirmative action programs with respect to hiring minorities.

It was also suggested that the Chairperson on selected HSA committees and the position of board chairman be mandated by law.

Other general recommendations included:

(1) Coalesce various national black interest groups under a concept of black health concerns;

(2) Utilize experienced consumers to train other consumers in their role responsibilities in all areas of HSA operations and management; and

(3) Establish a network for minority participation, advocacy and education at the local, state, regional and national levels.

In addition to discussing issues related to PL 93 – 641, the group expressed concern for the financial situation of predominantly black health professions schools, with particular emphasis on Meharry Medical College.

WORKSHOP III

Effecting Health Planning Strategies In The Black Community

Leader: Fred Adams, D.D.S., Chairman, Connecticut Health Planning Agency

Facilitator: Steve Wilson, Lowndes County (Alabama) Health Services Association

DR. ADAMS: I'm Frederick Adams and this is Workshop III. I'm listed as Fred Adams and that's not another person; that's still me. I'm from the University of Connecticut and my relationship to Public Law 93-641 is that I am State Chairman of the Statewide Health Coordinating Council of the State of Connecticut. I'd like to introduce you to some other people who are going to be working with you to make this a productive workshop. The young lady who is passing out material is a Project Associate for Expand Associates. Her name is Melvena Sherard. On my right, we have our Facilitator, Steve Wilson. Steve is Project Director of the Lowndes County Health Services Association, chairman of the Southern Association of Community Health Centers in Jackson, Mississippi, and Chairman of the Health Committee of the Southern Rural Policy Congress. The three of us – Melvena, Steve, and myself – will work at noon to try to encapsulate as many recommendations as you produce this morning. We'll work during the afternoon to turn them over to those individuals who are to articulate the recommendations coming from this Workshop at the 4:00 o'clock closing session.

I'm going to address a couple of issues off the top: The Congressional Budget Office study recently completed about black health; Public Law 93-641 and a capsule case study of its impact; power politics in health. Then we will open it up for discussion of things you have on your mind about the objectives of the conference. I want to make a brief remark about Dr. Reid Jackson and the staff of Expand Associates. I would be remiss if I didn't congratulate Dr. Jackson and staff on what they've done to pull a cross-section of people together at this conference for 2 days, from all around the country. We should encourage Expand Associates to keep expanding. They have reason to.

Let me quote from the Congressional Budget Office a study recently completed comparing the health of non-whites and whites. The study suggests that "despite considerable progress in narrowing the health gap between white and non-white Americans in the last 20 years, substantial differences persist." It goes on to point out various facts related to health indices, which I'm going to take time to mention briefly; these facts set the frame of reality we're going to deal with in making our recommendations:

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1) "Non-whites experience nearly 50 percent more bed disability days; 70 percent higher infant mortality and life expectancy 6 years shorter than that of whites." This gap used to be 7 years, so I guess all of us can feel that we've had our lives lengthened by at least one year.

2) "White persons make about 10 percent more visits to doctors than non-whites. Although the proportions of whites and non-whites hospitalized each year varies little, non-whites tend to remain in the hospital longer because they are sicker, particularly poor non-whites."

3) "Non-whites are 60 percent more likely to die of influenza or pneumonia and five times as likely to die of tuberculosis." The latter diseases are, supposedly, "conquered" diseases.

4) "The non-white male or female is nearly twice as likely to die with cirrhosis of the liver and more than seven times as likely to be a victim of homicide." These facts would seem to support Lowndes County's definition of mental health as a priority health service in that community.

I won't go over the access problems related to health care; the facts have been repeated over and over again by the other speakers we have heard. But I would like to make some comments related to P.L. 93-641, the National Health Planning and Resources Development Act of 1974. In order to set up the frame of reference for your remarks, let's examine a bit of history leading up to the creation of that law. I call your attention to the 1963 Act, the Hill-Burton Hospital Survey and Construction Amendments, and for those of you old enough to remember, the original Hill-Burton legislation in 1946; all the certificate of need aspects of that program now relate to 93-641. Many of you, I'm sure, were related to P.L. 89-239, the Regional Medical Program, and many of you were related to P.L. 89-749, the Partnerships for Health Act of 1966. Many have problems with the new law as written; it is the most comprehensive piece of legislation dealing with health care ever produced by the Congress. But in spite of its problems it is here and it is law and it gives rise to encouragement if you will look at it constructively. For the first time it brings consumers and even providers into the planning process. P.L. 93-641 challenges people from different walks of life to come around to the same table and articulate their priorities in order to put themselves into a frame of control and to deliver enhanced health services for citizens throughout the land. The HSA's in P.L. 93-641 become much more than the CHP's were, become much more than the consumer input into the Hill-Burton strategies of control, containment of cost, or creative retrenchment. Obviously, some consumers couldn't care less about health care. Some consumers are busy doing other things like surviving. But the planning input from those consumers involved in the process can be positive and constructive.

Let's look at the SHCC in Connecticut. The SHCC conducts health planning activities in the state, prepares and adopts a state health plan and a state medical facilities plan, and implements those portions of the state health plan which relate to the state government. It's broad even though gabby; it has a significant role as we progress towards the eighties. It administers a certificate of need program. It cuts into the politics of health and health care in any given region of the state; it reviews all existing institutional health services for appropriateness; it reviews, and approves or disapproves, certain state plans dealing with health and mental health programs. Now our charge is to figure out how 93-641 affects and impacts on health planning strategies that will benefit the black community, and that leads me to a case study. I'll go to Connecticut because I know the situation there and I'll talk about one of the things I like to talk about – power politics. The issue is inclusion versus exclusion. Philosophy versus an applied resolve. The Governor of the state called upon me early in 1975 to take leave from the university and come down to the Capitol to assume responsibility for designating service areas in the State of Connecticut. I had known the Governor when she was in the Congress. I had worked with her on health manpower, mental health and other things for 10 years, leading up to her callimg me to come down to the Capitol, to mobilize the effort that would significantly attack the final layout of the service areas. The people that I brought with me and the mobilization strategies which we implemented involved over a thousand people – urban centers, exurban centers, rural areas. The hearings we had throughout this state were open – no conclusion until the end. After all of that was done, it allowed us to have the maximum number of areas in the State of Connecticut - five - and the maximum number of people involved. In spite of the Connecticut Hospital Association and other groups who considered me not to be a "friend" of theirs, I had an opportunity to counsel the Governor before she made her appointments. As a result, the SHCC, a body of 32, has six blacks, two Puerto Ricans and one native American. A significant number of individuals, slightly over a third, are ready to do business and are ready to contribute to a state health plan. State health plans are important to our future. We've never had them throughout the country. Now a mandate is to have them in all states, the District and the Commonwealths.

There was only one state that rebelled significantly and you know that state without my mentioning it. It had to be Texas; they wanted to go their own way until it was demonstrated to them that to go your own way means that you pay your own bills for your health activities. Texas then complied with designs for health service areas, HSA development, SHCC development, et cetera. I mention that to you in support of what Dr. Haughton said yesterday about politics and how you intervene in the process, and that there are no options. You're either in it or you're not. If you're not and you're significantly competent and skilled, then you're part of the problem, because everyone can't be an intervenor.

Let me address now the objectives of this workshop. Our first objective is to define health planning in an operative framework for discussion purposes. I hope I've helped ready you for that, so that we don't have to spend too much time on objective number one. Objective two is to provide an up-to-date overview of the status of health planning as a national health policy strategy. We've had a lot of discussions on this objective in the other forums. Objectives three and four are very significant and I'd like for you to concentrate your attention on them.

Objective three is to determine the extent and nature of the involvement of representatives of the black community in the health planning process - local, regional, state and national. And four is to determine strategies the black community can utilize to ensure a better distribution and allocation of health resources, i.e., what can the black community do to secure physicians, dentists, health facilities, and health education activities in their communities for their tax dollars and what can they do to prevent the loss of existing resources? You all have copies of the objectives. Remember that we will try to concentrate specifically on information that we can utilize to formulate recommendations. Steve will be our Facilitator. He'll try to motivate you to contribute maximally. Mrs. Rita Howell is taking down everything you say. If there are no further questions about the ground rules, just raise your hand and I'll recognize you. Give us your name so that everyone in the room will know who you are.

MR. STRETCHINGS: I'm Frank Stretchings from New York City HSA. There seems to be a problem in getting maximum consumer involvement, especially in New York City HSA's. This problem is especially severe where there is an enormous amount of interest by the providers in the activities of an HSA. In your experiences in Connecticut, what would you say are the lessons about minority participation in HSA's, and how would [illegible] go about stimulating greater support efforts? Do you, for instance, believe that some sort of national center for minority health consumer participation might be needed? There is really no organization to promote minority participation in HSA's or to train consumers in the types of information analysis to enable them to participate effectively against hordes of providers who are being paid to do that.

DR. ADAMS: Quite well taken. I'm going to ask Steve if he will relate to that, because I'm sure he can address it much better than I. I've talked enough for the time being.

MR. WILSON: As your Facilitator, I think my charge is to try not to direct answers from the dais here but try and get maximum involvement. I don't know everyone, just a few people here, but I do know there are people here who have been involved in the organization of consumer participation in HSA's. Some of you have successes and some of you have failures. Will some of the group respond to the question raised by Mr. Stretchings?

MS. MILES: My name is Pauline Miles and I work for the National Health Council in New York City. I suppose I should briefly identify what the National Health Council is and then try to respond to the gentleman's question. The National Health Council is a national membership organization. It has five categories of membership. One of the categories involves all of the major national voluntary health organizations, such as the American Cancer Society, the National Foundation of March of Dimes, the American Heart Association, the Arthritis Foundation, Cystic Fibrosis, and so on. Other categories of membership are national health professional associations such as the American Medical Association and all the professional associations that represent such groups as occupational therapists and physical therapists. Another category of membership deals with the national organizations with an interest in health, such as the National Urban League and the National Association of Community Health Centers. Then we have another category of membership which involves corporations and insurance companies such as Equitable, Metropolitan, Prudential, and Provident. Our last category of membership involves segments of the federal government itself. Now I described the nature of the National Health Council because one of its member organizations is the American Association for Health Planning, which is a national organization whose constituent members are the health system agencies.

My background is in medical social work, but I have also worked in comprehensive health planning and have been very concerned about raising the level of consumer participation in health planning. I have been puzzled about the category of membership on the boards of Health Systems Agencies which is described as "indirect provider," because it seems to me that most of the people who make up that category are consumers who came into health planning during the years when comprehensive health planning was in vogue and because they served on boards of CHP agencies. Under the new regime they now are considered providers, and they live in a never-never land between the providers and consumers. But from my point of view the indirect providers, many of whom are consumers, consumer advocate groups or representatives, represent a very rich source of experience. It seems to me that this particular group should be tapped to try to attract more new consumers into health planning. We feel at the National Health Council that planning is absolutely the only game in town, and everybody wants to play. We believe that health planning is a political activity, and it seems to me that we have to grab hold of those consumers who have learned how to play the game over the past three or four years, take that talent, and apply it to community outreach, bringing in more new people who perhaps don't see health as a priority, and convince them that health is a priority. Instead of using necessarily staff people or providers to train consumers, why not use consumers who have learned how to deal with the system to help train others to do it for the agency. I also think that consumers who fall into the indirect provider category could, if they were offered internship training kinds of opportunities, become eligible to staff agencies. As staff, they would have a very particular sensitivity to the needs of consumers. You really must have very sensitive staff to work with providers and consumers in planning for communities.

MR. PUGH: My name is Robert Pugh. I'm the Associate Director of the Mississippi State Health Systems Agency, and we have had quite a bit of success over the past year in getting black consumer representation on our board. I think that one of the major drawbacks we are faced with is that the law itself does not allow consumers to have the input they really should have, and that the the law intended. As you all know, the law states that the boards must be broadly representative of the racial, social, linguistic and economic makeup of the health service area. Well, no one to this day has defined what "broadly representative" means. We need some definition of what that is. The law should be amended to insure that blacks be among the officers of the corporation or the officers of the board that makes up the health system agency. If the HSA's are going to be private organizations, the By-Laws should be written to give black providers representation on the boards. The law should be amended to provide incentives to employers to allow consumer representatives to take time off work and be reimbursed; they should not have to lose a day's pay for undertaking this very important planning activity. I think the consumer should be continually educated along the lines that the young lady was talking about. One of the reasons that the old partnership in health activity did not work is that the planning agencies were provider-dominated. Even now, with the consumer majorities on HSA boards, you still find these boards provider-dominated; consumers are intimidated by providers. They feel that providers have the expertise and the expert knowledge with which to make all the decisions. Of course this is not the case. But I find it very difficult to get the message across to consumers that they indeed have a voice. I think the law is going to have to strengthen that voice. We've come a long way and we have to face some facts. Having providers sit on planning boards is a bit like having utility executives sit on Utility Commissions. They just don't wash. Something is going to have to be done at the national level in amending the law to assure that consumer representation is indeed going to be effective. Consumers are going to have to take the leadership on these planning boards, and are going to have the legal authority with which to do so.

DR. ADAMS: Mr. Pugh, would you be kind enough to jot down those specific considerations you had about amendments or regulatory updates? I'd appreciate it.

MR. WILSON: Before we move on, let me give one illustration of age, race and other breakdowns required in the constitution of HSA boards. When HSA's were organized in Alabama, we took a 17-county area with three or four majority black counties and 12 or 13 majority white counties. The total makeup of the 28-member board of the particular HSA in which we operate is reflective of the total breakdown of population of that 17-county area. However, when a specific proposal comes from one of the predominantly black counties, that project is going to serve black people; there is no equal representation of the population to be served, on the decision-making body. So although the map works out in terms of equal representation in one respect, from another perspective it is grossly imbalanced.

MS. WILLIAMS: My name is Brenda Williams and I'm with an HSA in South Carolina. I think that in the absence of revised guidelines, there's something that staff people on the HSA's can do now. In South Carolina, black staff people have met regularly to discuss ways we can improve the effectiveness of consumer participation. I think if your staff people take some responsibility for getting information to the consumers, their participation can be improved.

MR. CURRAN: My name is Jim Curran; I'm from Texas. I think that one way to look at consumer input is to look at how an HSA structures its resources. We are fortunate in that we have enough money to take approximately 40 percent of our staff people and allocate them to the development of health councils. There are three sentences in the law that potentially have the most relevance to the poor blacks, whites, or chicanos. An HSA has two primary output documents. One is a health systems plan which defines a health environment. The other, more specific, more relevant things that the consumers can understand are evident in the implementation plan. Our strategy is to organize secondary health councils, do the necessary gerrymandering to see that they are representative and to let them, through adequate staff support, make the decisions as to what they do and what they do not want. The way the HSA allocates its resources can, I think, be relevant or irrelevant. A centralized office is going to do nothing more than just be centralized; that's where you have agencies that do marvelous plans and put them up on the shelves to stay.

MS. IRBY: My name is Betty Irby and I'm with the Bureau of Health Planning and Resources Development. Our bureau is charged with the implementation of 93-641. Our direct response to the question that the gentleman from New York had is whether or not it takes blacks to coalesce to really make the law representative and relevant. I would say yes. Even though the law stipulates that the boards, the HSA's, the planning agencies, on the whole ought to be broadly representative, what "broadly representative" means, won't be well-defined until the law is adequately challenged. Other groups have done it. The handicapped have done it. The aged have done it. And until blacks do coalesce to challenge the law and make it representative, I don't think it ever will be.

A VOICE: My name is Joe -- and I'm also from Mississippi. I'm with the State Health Planning Development Agency. I would like to address some of the concerns that you raised about consumer involvement. I don't know how some of the other states are in regard to having other types of agencies to work with out in the field, but we have what we call CAP agencies, which are community action program type organizations, human resources organizations out of the community. We also have local development corporations, which are black-oriented, that deal a lot with private enterprises. These are the agencies that operate at the grass-roots level in terms of getting out and recruiting people to vote when election time comes around. We have people actually politicking, and that's one of the ways our black staff members get around. My formal background has been with community action agencies, and they do get things done. Of course, another way is through black universities. They, of course, are interested in finding out what the HSA does and what SHCC does, and generally that is the way we go back and touch at the grass-roots level with consumers.

I'd like to address another area in terms of health planning. We've been talking about a lot of things in health planning for black folks, but it seems to me like we're still missing something. I've written quite a few proposals and they've gone over to Atlanta. The first thing they do is to question the validity of your data. The next thing they talk about is broad based community support. How can you have this when you're already a minority? You're just trying to go to a privileged majority, trying to get them to understand. Those are the kinds of things that we should address, and of course these things can be addressed in HSP clubs, health systems maintenance, and even in state planning agencies by the SHCC agencies. But I think we have to address all of those at all levels of care.

In Mississippi, we are overbedded by some 1500 beds. But I'll tell you we turned down a certificate of need application not too long ago. We only have one predominantly black hospital; it wanted to add seven additional beds and we couldn't let them do it. Of course, by our plan we are overbedded, but then again we should be sensitive to those needs. We also need to get into nursing homes. There are only 40 beds in the State of Mississippi that have an administrative base of predominantly black people. Those things have to be changed. And if you're talking about health planning you've got to get into all those health care areas.

DR. ADAMS: For those of you who do not know what SHP is, it's State Health Plan; AIP is Area Implementation Plan; HSA is Health Systems Agency; HSP is Health Systems Plan and SHCC, if you're not tongue-tied, is Statewide Health Coordinating Council. SHPDA is State Health Planning and Development Agency.

MR. CLARK: I'm Frank Clark from Pennsylvania. The question is how to get black communities to make health planning work for them. I'd like to propose something that's already been suggested. To make health planning work the black community must set up an organization base from which to operate. That's one proposition. There must be an organizational base. Whether it's the NAACP or the Rural Health Cooperatives or somebody on an organizational basis that has resources, communication and staffing, to take an interest in health and from that organizational base to begin to move in two ways that impact on health planning. Some of them have already been enumerated but I want to put out for all of us the consideration that if we are to make health planning effective it must be from the black community's point of view, but somewhere in that community we must make all our initiatives from the organizational base. That organizational base then will provide the political base and the brainwork for accountability, the models for communication, and the ability to mobilize resources in order to be able to advocate a position. The community has to be able to hold people accountable inside those organizations. Secondly, we have to see what the HSA's are all about. When you come in with a Neighborhood Health Center proposal or primary care proposal that's going to compete with the local hospital, that now wants to get into ambulatory care, you'll find that they don't mind making blacks walk 5 miles or take a bus 5 miles and say "You've got care. It's about 5 miles down the road." Then you see what the HSA is all about.

So that's two propositions. First, we have to start from an organizational base. Second, the black community has got to do its own planning.

MR. CURRAN: Yes, I was wondering if anybody could respond to a question that I have as to the role of the black provider and the role of the black consumer. Being a white man and fairly familiar with overall strategy, I know that white consumers are often at odds with white providers. It seems that the same kind of difference might occur in the black community between consumers and providers, when the vested interest of the black providers is possibly at odds with the health care needs of the black consumer. I wonder if there is much validity to my assumption, and how such a coalition as the lady is advocating would address that situation.

MR. STRETCHINGS: In New York City, we don't have that problem because there are no black-owned or run hospitals, or even black-controlled health providers organizations, that have a major impact on the black community. There is a basic unity between black providers and the black community, so I don't think there's any real conflict.

MR. WILSON: I can respond a bit to show how a coalition can be effective in terms of need. The Health Service Corps provides medical and dental personnel in certain areas. There is a certificate of need requirement. The area professional society governing the particular specialty for which the provider is being applied for, medical or dental, must certify that there is a need for additional manpower in that area. In Lowndes

County we had an application in 1974 that was not staffed until 1976. The process was blocked by the area dental society, which was a unit of the state dental association. After seven contacts with them, and seven votes of the executive committee, all of which went against the addition of a dental provider in Lowndes County (in which there are about 15,000 people and only two dentists), we then turned to the black dental association for that area of the state, which certified the need for additional dental manpower in that area. We then confronted HEW with the situation. HEW chose not to accept the black professionals' opinion, but subsequently overrode the white professionals' opinion. This is significant in what it shows about the potential impact of a coalition between black professionals and the black community relative to regulatory and statutory provisions in the Public Health Service Act.

MS. MARTIN: My name is Alda Martin and I'm from Atlanta. I work for the Department of Medicine at Emory University. What I'd like to address myself to is somewhat different; I'm in the provider role. I'm a primary care person for about 1,000 poor blacks. The one thing that I'd like you who are health planners to think about in planning policies for blacks is that there is a whole group of people who seem not to be recognized as providers for health care for blacks; the group I refer to is nurses. Nurses are now in primary care roles, functioning as primary care persons for masses and masses of black folks. In my clinic, there are five nurses who are responsible for the total health of a thousand people. I just want you to be aware that we're here and that if you want the help, utilize us in planning strategies for the health of blacks.

DR. ADAMS: I see that many of you still wish to speak, but we must discipline ourselves to meet the timetable. This afternoon we will address objectives 3 and 4.

WORKSHOP III

AFTERNOON SESSION

DR. ADAMS: For the sake of anyone who may be lost, this is Workshop III and we're dealing with Effective Planning Strategies in the Black Community. I would like to call on our recorder, Miss Sherard, to fill you in on what we did this morning.

MISS SHERARD: At this point we've come up with three recommendations that are in rough form. These recommendations will go to Dr. Cornely and Dr. Thompson who will present them to the forum as it meets again before the closing of this conference. The first recommendation is that there be seven amendments to the Public Law 93-641. The seven amendments would allow consumers to have legal and persuasive authority to control health planning policies in their service areas:

1) To define the term "representative" in the law, as it relates to the social, racial, linguistic, and economic, makeup of HSA governing boards.

2) To revise the law to ensure representation from a broader range of health manpower, other than physicians and nurses, dentists and optometrists. The new groups, such as physician extenders and allied health professionals, should have more specific representation.

3), To ensure that minority providers in all categories are represented in the HSA board.

4) To encourage the employers of consumers to pay their employees for attending HSA and SHCC board meetings.

5) Board members should be reimbursed for certain out-of-pocket expenses incurred while attending board meetings, such as babysitting.

6) To limit the power of providers on HSA boards, by increasing consumer representation to 75 percent and providing that both chairman and board president be consumers.

7) To ensure that affirmative action programs for minority hiring of staff are undertaken and adhered to.

MS. IRBY: I think there's something wrong with that language.

MISS SHERARD: This is very rough.

DR. ADAMS: All right. Maybe we can clarify that right now. Robert, why don't you try to clarify your intent?

MR. PUGH: My intent is that the law not lay out guidelines as to the structure of the governing bodies except in terms of numbers and representativeness. I heard someone earlier this morning say that the old consumers are now the indirect providers from the old Partnership for Health Act and that we need to get more of their input into the governing bodies of the HSA's. One of the problems we have is that many of these so-called consumers are actually controlled by providers. In fact, they have been set up by providers to be consumers and the providers actually pull the strings. I think we need to get away from that. I'm not saying that providers should be closed out totally, because I think there is a need for providers on these boards. But I think that there should be some way of amending the law to allow the strengthening of the consumer position on these boards such that consumers can actually do the planning rather than providers doing the planning for profit. So I'm thinking in terms of having the chairmen of the various committees like Project Review, Planning, Development, and Plan Implementation, as well as the board president, be limited to consumers.

There are a couple of different structures of HSA's and maybe this is where the confusion is. Some HSA's are public bodies which are run by County Boards of Supervisors or some other municipal or state controlled mechanism. Some HSA's are private corporations that have contracts with the regional office to carry out the responsibilities of the law. I think whatever the particular structure that you have in your area, it should be such that consumers have the leadership responsibility and are able to carry out that responsibility. In Mississippi we have the private corporation under contract, and I notice that the providers are all officers of the board and the executive committee and, of course, they call the shots. I think we need to attack that structure, so that the consumer domination that the law intended can really be carried out.

MS. IRBY: So you want some kind of consumer monitoring or some kind of device for enforcing consumer representation or consumer majority?

MR. PUGH: Yes, within the law itself.

MISS WALKER: Well, the law states that 51 percent of the members have to be consumers.

MS. IRBY: You've assumed that they're going to follow through with the intent of the law, but you have no mechanism for enforcing it.

DR. ADAMS: That's right. He's saying that this should be in the regulations, to make them more specific about the increased role of consumers.

MR. PUGH: If we're going to make policy recommenations here, I think this is what we have to be about, saying this is what's happening, and this is what's wrong, and this is what's keeping the law from being implemented the way we think it was intended.

DR. ADAMS: Please hold that thought; I'll get back to you after Melvena completes her update.

MISS SHERARD: The second recommendation is for the establishment of a consortium of black health concerns, on a national basis, to articulate priorities and provide policy planning to maximize the role of consumers at all levels in comprehensive health planning, and to establish a network for minority participation, advocacy and education at the local, state, regional and national levels.

The third recommendation is to increase the political astuteness of responsible members of HSA's and SHCC boards and their related professional staffs, so that they can mobilize consumers in a political way to participate in elections to enhance black representation on the aforementioned boards and related professional staffs.

The fourth recommendation is that the black community develop a strong political base to command attention and yield results from HSA's, SHCC's, and SHPDA's, and to foster staff accountability at each level.

The fifth recommendation is for inclusion of all types of black health providers in the process of health planning, particularly those professions that have been traditionally excluded from the primary health planning process, i.e., nurses, podiatrists and allied health professionals.

MS. WALKER: I want to speak to the point of getting more consumer participation. Our problem is not so much having the law spell out how many people or how many consumers should be on that board; it is in recruiting minority people to serve on the board. The way announcements are made and the way people are invited to participate does not foster good black participation on our board, and even after we get on the board, the materials that we have to handle and the kinds of things we have to do are very foreign to us. Whether you like it or not, there is a special jargon that providers use that consumers must learn if we are going to be involved in the planning process. No matter what the law says or does, it is not going to help us unless we, ourselves, begin to prepare our people to work on these boards.

I would suggest that each community have a local group, made up of all the agencies and organizations which serve black people, to come together and recruit consumers, train them, and get them oriented toward serving and being advocates for black people. Right now most of the consumers are advocates for the system, and as I see it, we must select people to serve on these boards who will be advocates for our people; it's not an easy job. You have to read reams of material if you're going to be effective. You have to attend task force meetings and serve on task forces for planning. You have to know something about planning and this is very difficult for our people. You can't read this stuff if you don't have a high school education, and even with a high school education, you can't read and understand some of this stuff. So we have to work very hard if we are going to get our people to become instrumental in planning.

DR. ADAMS: Very well put.

MR. ALEXANDER: I'm Raymond Alexander from the Health Systems Agency in Norfolk, and a consumer on the Board of Directors. We get caught in between the staff who brings in all this data about what should be done and what their predictions are, and the providers then bring in their technical jargon about what's best for the area, and we're caught between the two groups. Who do you represent? You're appointed by the City Council, in my case. Who do you represent in this case? The blacks? The county you came from? Or the region? It's a regional board that you're appointed to.

MR. WILSON: Ron, can you speak to that?

MR. AUSBROOKS: I think the question should be asked, but I think we should step back a minute. Remember that the boards have the ability to hire the people who represent them professionally. But you still have to develop some mechanism to make those individuals sensitive to the board they're trying interface with. The board approves plans. They determine who is going to be hired. It is then the responsibility of the professional staff to digest the technical materials and present them coherently, so that members of the board can understand the issues. I think the solution must begin with the professional schools and the schools of public health. We must sensitize professionals, as a part of their training, to alleviate the kind of problem you are talking about.

DR. ADAMS: We have about another half-hour after this. I'm going to ask you to cooperate with us by restricting your comments for the next half-hour to definite recommendations.

MR. CRAWFORD: I'd like to make a recommendation that 93-641 be amended in some fashion to require that HSA's have some slots reserved for paraprofessional staff. The rationale is probably self-evident. Paraprofessionals who could perform invaluable functions in terms of outreach, in relating to disadvantaged communities, in breaking down the technical matter that HSA deals with and interpreting it to the community. Then they could perform a valuable function in humanizing the activities of the HSA's, and at the same time get themselves better prepared to move into professional positions.

MR. WILSON: Let's try to move to objective 4. Number 4 is something that we have not dealt with in a focused manner; it is to determine strategies the black community can utilize to ensure a better distribution and allocation of health resources. What can the black community do to secure physicians, dentists, health facilities and health education activities in their communities for their tax dollars, and what can they do to prevent the loss of existing resources?

MS. WALKER: Many times we don't use effectively the services that are in our communities, and thereby lose them. It's not because we don't need the services; we often just don't know that they are there. In addition, some services that are available are not acceptable to us. When I use the term "acceptable" I mean that they reduce our dignity and not meet our needs in terms of supplying information vital to our way of thinking and our culture. For instance, you go to the doctor and he speaks to you in a language that you cannot understand, he talks to you in a way that you don't know so you can't provide him any information about your problem. You're given medicine and told to go home and use it, or you're put on a diet that you cannot follow. So as I see it, what we need to do is to begin to get professionals to think in terms of providing us with medical care that is acceptable to us. And if it's going to be acceptable to us we must have some input into the kinds of services that we are going to get. We must get our people to become righteously indignant about services that do not give us some sense of dignity. Our people are not coming into the clinics because they don't feel comfortable there, so the clinics and other services disappear from the community.

MR. WILSON: I'd like to interject something here. I operate a community health program and I say to my staff "I'm very tired of people being treated better at McDonald's than they are here at the health center."

MS. THURSTON: I'm Maxine Thurston, executive for the Houston HSA and I want to comment on objectives 3 and 4. Part of the problem of community participation has to do with the kind of information that is given to the boards. Information gets sifted out by the staff before it gets to the board. The initial data have already been formulated conceptually and philosophically to a very strong extent by the professional staff. Community representation on the staff is important, but there is nothing that requires any kind of affirmative action program in the employment structure of HSA's. A follow-up is needed to the standard non-discrimination statement. We've been letting people get away with the assumption that we have to be superqualified to hold a professional slot. There are many blacks with planning skills. They may not be health planning skills, but if you can develop a good plan you can learn to adapt that to a new field. What we've done is to give away our rights, by allowing ourselves to be set aside in those little unimportant jobs that don't allow us to grow or become promoted. So one of the things I would like to suggest is that we recommend that there be some follow-up affirmative action with staffing of health systems agencies. My second suggestion is the establishment of sub-area health councils. This is something the current legislation leaves up to individual agencies. It is not something that has priority. However, if we're going to plan for the particular needs of our communities, we've got to have a group that can produce a specific community plan that does not get diluted into a consensus of the general community where you've got 2 or 3 million people.

MS. MILES: I would like to make a recommendation that has to do with building a capacity for developing skilled staff. We should encourage health systems agencies to develop internship programs which would serve as a bridge between the schools and universities, that are training health planning staff, and the operating agencies; health systems agencies should be required to serve as training laboratories for recently graduated health planners, so that the health planning students begin to develop some expertise within the operating agency and hopefully can move into full staff positions as they become available.

MR. WILSON: I'm bound to try to focus the discussion. I don't want to be heavy-handed, but I do want to say that under objective 4 there are some specific issues that need to be addressed. That includes the current allocation of resources with respect to community health services, the status of health manpower, minority health manpower, specifically the Public Health Service program, the status of black hospitals, and public information and community awareness in terms of health policy.

MS. YUILLE: My name is Judy Yuille from Pennsylvania. I'm a representative of Mercy Hospital Committee on Neighborhood Health Care. Much of the discussion that has gone on seems to start from the top. Those who are planning and creating policy hope that it will filter down to the consumer, and that patients will eventually benefit from the policies and plans that have been made. The committee which I represent, or somethink like it, could encourage regional and general hospitals to provide advisory boards from their primary service areas to meet the needs of consumers in those areas. These

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boards could help meet the needs of consumers on a level that they can understand, on such topics as the operation and location of emergency rooms, health centers, and outpatient clinics, where the people are receiving direct care.

Even though I represent a consumer board, I am a provider by definition and I think it's important that providers volunteer their time to assist in the education of the consumers so that they can coordinate and assist in the plans that are being made at the top. The problem now is that there is no connection between the two. The consumers too often do their own thing while the planners are attempting to get the word out to them. But by and large most people don't even know what an HSA or HSP or AIP is.

MR. FOSDICK: My name is Jim Fosdick and I'm Assistant Director for Health at the National Institute for Advanced Studies, which is a minority-owned and predominantly minority-operated research organization. I wanted to describe a project going on right now, which provides an opportunity for affecting the health planning system. Clay Simpson's Office of Health Resources Opportunity, in conjunction with the Bureau of Health Planning and Resources Development, has given us a contract to develop a mechanism for monitoring the extent to which HSA's and SHCC's are meeting the needs of blacks and economically disadvantaged people. Over the next year we will be visiting 23 state and local health planning bodies, and we would welcome the participation of any people who want to influence methodology development. The intent at BHPRD is to develop a mechanism for evaluating the performance of these HSA's and SHCC's, and to see whether they are actually effecting any real changes. So we have to come up with ways of evaluating their decisions, ways of evaluating where they put their resources, and give BHPRD something that they can use to influence the activities of these agencies. We would welcome anybody here getting in touch with us and providing input, as to what we should look at and how to look at it in terms of improving health care in the community.

MR. BERRIEN: I'm Charles Berrien, NIMH. One of the things that we have to do is to look at everything that affects us in the area of health and figure out how we can control it, rather than just being a part of some body that has responsibility for it. What comes to mind is a community mental health center in Chicago that is run by Dr. Wright. It is the only community mental health center I know of that is completely controlled by blacks. They control all of the money that comes into the Garfield Park area that has anything to do with mental health. It is unique, and I think it is the very thing that we need to be about, not just being a part of a system but taking primary responsibility for those things that affect us.

MR. WILSON: If I can take one minute. The HSA's have a unique relation to HEW in Alabama. I can't speak for other states. When HEW wanted to develop rural health initiatives they went to the HSA's and said develop us some applications. The HSA's then went out to the communities. Very few, if any, of those were black, yet they developed at least 17 applications. The HSA has the responsibility to work with the community organizations who wish to apply for funds and I don't think that there were any constituent representatives in the predominantly white communities that had any better expertise than the predominantly black communities in Alabama. So I think that the accountability factor has to be dealt with in terms of the communities that receive assistance from HSA's. Subsequently, other community organizations have got to be involved. They should not be fearful of making application for funds, regardless of the outcome.

MR. COVINGTON: I'm Larry Covington, Program Director and District Director of the Pittsylvania County Sickle Cell Anemia Association. I was sent to this conference by the NAACP. In the State of Virginia, lawyers have gotten together to provide legal information to the public. If a person has a question about legal terminology, there is a hot line to provide a quick answer. But many people in my community are going to doctors and getting prescriptions or medicine. They don't know what they're taking or why. The physicians are not taking the time to explain these things. We need some type of recommendation that health professionals form a kind of "health-line" to provide information to consumers. Maybe it's not a problem in your communities, but it is in Danville and I think across the State of Virginia.

DR. BEST: I'm Marie Best from the College of Pharmacy at Howard University and I'm glad you brought up that situation. I would suggest that the pharmaceutical association in the community also become involved. Pharmacists in other states have become very heavily involved in the education of consumers on just the kind of thing that you're speaking of, and I would be glad to offer my services to you, both here as well as in Virginia.

MR. FOSDICK: It seems to me that the question that he's raised goes beyond health education. Some of the things he's talking about might fall under an ombudsman program. The ombudsman is a citizen's representative or consumer's representative and beyond just educating consumers, the ombudsman could resolve complaints that the consumer has with the health care system. I also have an objection to having physicians provide the information; they're going to give the consumer the information they want the consumer to have. It might be better to put this information service where you could be sure that the consumer's interest is being represented. Perhaps we should recommend that the Health Systems Agency establish an ombudsman to respond to complaints and provide information.

MR. WILSON: Do you accept those amendments to your recommendation?

MR. COVINGTON: Yes

MR. FOSDICK: I might add that the Administration on Aging has just published a document on how to develop an ombudsman program. The technology is already there and it would simply be a matter of transplanting the idea to a Health Systems Agency or some other consumer organization.

MR. ALLEN: I'm Thomas B. Allen of the National Pharmaceutical Association. Speaking on the issue of consumer health information to the general populace, it is a national concern. We get feedback all during the year on this problem. One solution could be to ask the various pharmaceutical associations to provide information and to send speakers to your group meetings.

MS. THOMAS: My name is Michele Thomas and I'm a Health Careers Counselor at Norfolk State College. I would like to make a recommendation in the area of health education. I don't feel as though the predominantly black institutions are really addressing the issue of educating our young black brothers and sisters in the area of allied health. There are more than 230 allied health professions that many blacks aren't even aware of. We need to train our own instead of sending them to predominantly white institutions.

MR. AUSBROOKS: I'm a doctoral student at the University of Massachusetts and I work for the U.S. Public Health Service. There has not been a lot of money directed towards health education, but the way materials are developed for health education are not geared for the consumer. They're geared for the professional. One of the recommendations I'd like to make is that we request that the Health Services Administration, NIMH, and other government agencies develop those materials for the population that's to be served.

MR. TAYLOR: My name is Don Taylor. I'm from Norfolk State College, Director of Health Sciences and Services. I attended many of these conferences; as Khayam said "I always leaves by the same door by which I came in." We sit here and we philosophize. We try to get plans of action. We try to get things going that are supposed to have wide-ranging effects. When one looks at all of the black health organizations that there are in this country today, you can't help but wonder how in the world we got into the fix we're in now. It seems that there is no coordination at all among the black health-related professions or associations that are all working on the same problem. For instance, we talk about the national pharmaceutical group, the National Association of Health Services Executives, and many others. The list is almost endless. We're going to have to come up with a concerted effort to get a registry of all the black organizations in this country that are working on the problems of health. Once we get that register we must then address four or five basic issues. Without this kind of coordination, the next conference will come back 5 years from now and talk about exactly the same problems we have today.

MS. DIXON: I'm a podiatrist at the VA Hospital in Tuskegee, Alabama. I want to say something in regard to education. One of our big problems in our high schools is to get counselors aware of the opportunities that are offered our children. There are about 200 or more health allied professions that students can go into. We really need to get into the high schools and start training our children for health careers. If you wait until they get in college they're already lacking some of the requirements needed for that particular profession. So we need to go into the high schools and start the training. The other thing I wanted to say is that we have all of this information, but there are people who are really in need of services and they're never reached. They don't know about the programs. One way that we might reach them is through the churches. In smaller communities especially. We can get help through the churches.

DR. ADAMS: Thank you very much. I know that we could continue forever, but the young lady from Howard is going to have the last comment.

DR. BEST: We have many things to do. Professionals have a responsibility to go to the PTA's, to go to the Welfare Rights Organizations, to go to the Welfare Building, to go to the churches, to speak to the consumers. Most schools have community service projects. Go out where they are. Start the VD education at a lower level in the schools. People welcome this kind of thing and this is the responsibility of everyone in this room.

DR. ADAMS: Thank you very much. You've been really committed and it's been nice to work with you in Workshop III.

WORKSHOP IV

IMPROVING HEALTH SERVICES FOR THE BLACK COMMUNITY THROUGH ALTERNATIVE HEALTH FINANCING SCHEMES

LEADER:

William Darity, Ph.D., M.P.H.
Professor & Dean
School of Health Sciences
University of Massachusetts at Amherst

FACILITATOR:

Donald Henderson, M.D., M.P.H.
Los Angeles, California

OBJECTIVES FOR WORKSHOP IV

IMPROVING HEALTH SERVICES IN THE BLACK COMMUNITY THROUGH ALTERNATIVE HEALTH FINANCING SCHEMES

This workshop is supplementary to Workshop I

SPECIFIC OBJECTIVES

1. To discuss the need for better health services in the black community, with a specific focus on the black family;
2. To identify the sources of existing financing and reimbursement mechanisms to pay for these needed services;
3. To analyze the extent to which existing public and private sector financing mechanisms pay for services to black and "working class" America;
4. To determine whether black America would benefit from the proposed methods of financing health services that are currently being espoused. This question must consider:
    - Methods of paying for health services,
    - Education, training, and research, and
    - Health facility development in the black community.

SUMMARY OF WORKSHOP IV

The participants of this workshop were involved in a very intense interaction. The group recommended substantive strategies to deal with resource constraints in improving health services in the black community. The general recommendations included the development of a preventive health care delivery model reflecting the needs of blacks and minorities. This model should include:

1. The development of schools of allied health, and staff development and educational programs for non-formally educated health workers;

2. Financing of the proposed model system on a capitation basis from federal and state treasuries; and

3. Monitoring and auditing this proposed structure through a decentralized National Black Health Care Association with a five-year revolving membership comprised of the range of health professionals.

This workshop also called for a model of health prevention and maintenance based upon the needs of the black community. The data from which to assess the level and type of care required for acute needs and for health maintenance would be determined by black health services researchers. The focus of this prevention model must include nutrition, health education and counseling. Recognizing that there are few blacks trained and interested in health services research at this time, it was recommended that federal funds be made available to select black and white academic institutions to educate and train young blacks in health services research. Other recommendations, suggestions and comments focused on the need for blacks to become actively involved with health planning agencies in state and local governments, and to communicate with federal legislators to emphasize the importance of health in the black community. This latter suggestion included in the definition of health a concern for employment and housing. A concern for the involvement of blacks in formulating health policy was emphasized, including an involvement of black colleges and universities in the research efforts required to do an effective job of formulating health policy geared to the needs of the black community.

WORKSHOP IV

Improving Health Services for the Black Community Through Alternative Health Financing Schemes

Leader: William Darity, Ph.D., MPH, Professor and Dean
School of Health Sciences, University of Massachusetts at Amherst

Facilitator: Donald Henderson, M.D., MPH, Los Angeles, California

DR. DARITY: Our discussion is going to deal with improving health services to the black community through alternative health financing schemes. Now I don't plan to make a speech because I think this is not what we're here for, with the little time we have. I would like to see if we can set up some ground rules in order to have an effective discussion. I would suggest that we try to limit our speeches to one minute. I'm hoping that because of the time factor that we can get started now, and at 12:15 we will break so that you can go directly to lunch. After lunch we'll only have about another hour to work toward what we want to do. Now I think I'll just start very quickly and take a second for everybody to say who they are. I'm Bill Darity. I'm from the University of Massachusetts.

DR. HENDERSON: Donald Henderson, Los Angeles, California.

MS. SANDERS: Frances Sanders. UC Berkeley, School of Public Health.

MS. PILGRIM: Juanita Pilgrim, Lincoln Community Health Center in Durham.

MS. BROWN: Jeri Brown, New York City.

MR. WOODS: Larry Woods, graduate student, social welfare, Stonybrook.

MS. HARRIS: Dorothy Harris, Georgetown University, D.C.

MS. ROGERS: Constance Rogers, Columbia School of Public Health.

DR. GRAY: Lois Gray, HEW.

MS. RUSSELL: Lillian Russell, University of Washington, Seattle.

MR. WARE: Gary Ware, Mental Health Department, Morgan State.

MR. RADEN: Tork Abdul Raden, I'm Manhattan Core Director for the Health Assistance Agency in New York.

MS. SCHRISDEN: Sharon Schrisden, HSA, New York.

MR. ISAACS: Walter Isaacs, Lawrenceburg, Mass.

MS. HOWZE: Dorothy Howze, Harvard School of Public Health.

MR. CLARK: Marvin Clark, Norfolk State College.

MR. JOHNSON: W.W. Johnson, St. Augustine's College, Raleigh, North Carolina.

MS. CAREN: Bernice Caren, Systems Health Services Plan.

MS. CALHOUN: Rosemary Calhoun, North Jersey Community Health Center.

MS. MORGAN: Sharon Morgan, Provident Hospital, Chicago, Illinois.

MR. SMITH: Edgar Smith, Institute of Medicine, Washington, D.C.

MS. WARREN: Michelle Warren, University of Michigan, School of Public Health.

MS. STODDARD: Adrienne Stoddard, University of Michigan.

MS. WRIGHT: Stephanie Wright, University of Michigan, School of Public Health.

DR. DARITY: Thank you very much. This gives us a general idea of who you are. If you'll look at the objectives, you'll see that our main purpose is to discuss the need for better health services in the black community with a specific focus on the black family; to identify the sources of existing financing and reimbursement mechanisms to pay for these needed services; to analyze the extent to which existing public and private sector financing mechanisms pay for services to blacks and working class Americans; and to determine whether black America would benefit from the proposed methods of financing health services that are currently being espoused.

I think most of us know some of the present mechanisms, particularly the private mechanisms that are tied in with various public support. We have Medicaid and Medicare. One of the problems that we have with most of our health financing systems at the present time is that they are *illness* oriented. They lack preventive coverage. I don't think I need to go into the health status of black Americans. We've heard that. I think maybe the best thing to do would be now to open this up. Let's take a few minutes to see how you would like to approach the objectives. I would like for us to stick to our objectives, to keep our discussion focused on these objectives. Let's not try to set up any more objectives. So I'd like to now open up the discussion and get some of your opinions. What are the needs for better health services in the black community? What are some of the problems?

MS. PILGRIM: I think the problem that we see in our community is that a lot of people who are most in need of health care, and who have been left out of the system the longest are the ones who are not coming in, because there's a lack of money for outreach and transportation and education for these people. Then once they get into the system, HEW begins to cut the money back. They say, "You have to bring in more people who can pay for these services and take in fewer people who are unable to pay." So I think accessibility is important, and acceptability by the patients, and making the patients feel that they have a right to health care. This is not something we're giving to them now.

DR. DARITY: Maybe one of the things we need to think about is to get some sustaining legislation for health financing over a period of time, say 50 years. We need this type of commitment for the black community. But if we have a health care program that's good for the black community, it will be good for all of America. Another thing that would probably have a lasting and continuing effect on black Americans is to revamp the system.

MR. RADEN: I understand what you're saying about trying to revamp the health system. But just revamping the system for black people or for any people in American society is not enough. You still have unemployment. You still have inadequate housing, poverty, and you still have ignorance. In my community, you can't deal with health unless you deal with housing, unemployment, poverty, and ignorance. If we're going to make any significant strides in improving the lives of black people, we have to deal with those areas.

A VOICE: I agree totally. But too many times we approach problems by saying "We need to change what we already have and we need to add additional services." It would be better if we tried to develop a mechanism for integrating all of the social service agencies that already exist in the community. The problem is that these agencies do not work together. You have the Health Maintenance Organization or the Neighborhood Health Center functioning over here. You have the United Way functioning over there, and you have the YMCA or whatever over here. We need a way to integrate these services, so that they will function for the total family and resolve some of these problems.

DR. DARITY: As we talk about ways to provide better health services to the black community, we need to think about a mechanism for integrating these services to get the maximum impact.

MS. PRICE: I would like to suggest two specific needs in terms of better health care for the black community, with specific focus on the black family. One is better family planning, including access to abortion when so desired. The second one is better facilities for the aged, particularly nursing homes with appropriate support and medical staff. I also want to include special attention to adolescents in my first recommendation. There are different needs for adolescents, even though they are part of the total family care system. But there should be more emphasis on some of their needs, and that kind of service is not now available.

DR. DARITY: Any program should give a very high priority and major emphasis to that particular group. I think it is clear when we look at drug abuse and other problems of adolescents, that we need to deal with them as a special group.

MR. ISAACS: I would hope that when the regulations get promulgated for program funding, that it's not set up so that groups become competitive for the same dollars. One of the difficulties of integrating services is that we're competing for the same dollars. And we draw very fine lines marking our turf. We should be willing to work with each other.

DR. DARITY: I think that the idea was to try to prevent that by trying to integrate services and program. Sister, what did you have in mind on that?

A VOICE: What I had in mind was basically an effective referral system, which I think is lacking in most agencies.

MR. ISAACS: My point is that you get funding in categories based on medically underserved areas. In the area where I work, there are ten community health centers with a two-mile radius. There are about 15 hospitals. There are overlapping medically underserved areas. The competition for the same dollars gets set up at the funding end. I'm hoping that whatever we recommend, we try to insure that the regulations are such that we do get comprehensive and integrated services.

MR. WARE: What we need for the black community is a preventive model of health care delivery. What's critical is that manpower related to the delivery of primary and preventive care be funded at the same level as secondary and tertiary care. That's not so in this country at this time. We spoke earlier of a total family approach to alleviate the problems of health care. That starts with a preventive model of health care for the black community.

A VOICE: Is there a chance for a question?

DR. DARITY: Of course.

A VOICE: I'm from Forsythe County which has a very large medical center that serves a large portion of the people in the Piedmont area of North Carolina. We have a situation there that some of you may be able to help us with, and thereby help other counties with a similar problem. Even though we do have these large medical centers, we are designated as a partially underserved area because of poor distribution. The situation there is not political in the sense that it's in the open. The situation is that there's a small group of individuals who control the area. They're not elected officials, and they do not come out in public. But they can be identified. The end result is that in the medically underserved area, dollars are available; but these dollars are circumvented to meet the needs or desires of the silent power structure. So what should be a community health center ends up being a place for interns to train. The physicians there are teaching rather than practicing. Apparently some of you have active community health centers with fully qualified physicians, rather than students providing health care. I want to know how you went about doing that, so that we might use your methodology.

DR. HENDERSON: That's an excellent question. Perhaps we should identify somebody here now who could respond to it at length with you, because I think it requires the kind of answer we can't provide in the time we have.

A VOICE: Well, my thinking is that we're not alone in this.

DR. HENDERSON: You're probably not.

A VOICE: Most of black America is in this same situation. I don't know if we are addressing the problems of most black Americans at this point. What we are addressing now appear to be the problems of those fortunate black areas that have already overcome many of the problems most of us are experiencing.

DR. HENDERSON: It sounds like your question is one of having a community health center that's adjacent to or connected with a medical complex, but the center has difficulty finding full-time physicians.

A VOICE: No, it is not.

DR. HENDERSON: Then maybe you should explain a little more of what the problem is.

A VOICE: I think someone has already mentioned that dollars are allocated on the basis of high risk or need. What I'm saying is that in many black communities throughout the country, the dollars are available. But these dollars, instead of being utilized for the intent of the law, are utilized at the discretion of silent groups. Instead of providing primary first-quality care, it's a training ground, like the old Bellvue situation.

DR. DARITY: I'm not trying to cut this off, but I think there are problems in other areas. I think everybody realizes that there are problems. I think that you're asking for solutions.

A VOICE: No. I was asking if anyone here has overcome this kind of problem.

MR. RADEN: Maybe I can tell you how to overcome it. If you submit a proposal to HEW or to any federal funding entity, and your proposal states that a specific type of service is going to be delivered, and if those services are not delivered, then the onus is on the funding agency to make sure that that's being done. So, therefore, if you have a complaint against a primary care program for not delivering services, you should go straight to the funding agency.

MR. SMITH: I'd like to change the focus a bit. The point I would like to make relates to the earlier point the brother made about prevention. There's a need for more health care education in the community.

DR. DARITY: I think that gets to what she's talking about here and what Brother Raden was talking about, which is that the community is going to have to assume some responsibilities. Until they do that, we won't solve many of our problems.

MR. WARE: The models that are used to educate health professionals and to staff health agencies do not speak to that. The funding sources are funding M.D.'s and nurses and not health educators, because the models for that are not in place. So the models have to be developed.

A VOICE: I think his point is very well taken. We're saying essentially the same thing. First of all, there should be training money available and appropriate kinds of programs developed for training health educators, including nutritionists. If you just put a program in place without trained personnel, it won't go anywhere. I would agree with everything he said, and urge that third parties extend funding, without having strings attached, for reimbursement purposes in training health care personnel including health educators.

A VOICE: There was a bill passed last year for health education. And for the entire country the total allocation was seven million dollars. So there's something wrong with the priorities.

DR. DARITY: It is woefully low.

MR. JOHNSON: I keep hearing about health education, including nutrition, I recognize this as a big need in public health. I'm thinking about all ages, from prenatal throughout life, because there are things that are deadly in our eating patterns that need to be looked at so that we will get the proper nutrients from the available food in this fine country.

DR. DARITY: We've looked at some of the needs for better health services. I don't think we've covered them all. This is just superficial. But I think we have covered some of the things that are identified as peculiar needs and services for the black community. We're now getting to the issue of the sources of existing financing and reimbursement mechanisms to pay for these needed services.

A VOICE: I suggest that in view of the conversation, that it's not only a matter of identification, but one of control and influence over health care financing.

DR. DARITY: Okay. Let's talk about that. Would you like to address that now?

A VOICE: Not necessarily. But it seems to me it's not just a matter of identification, but of having an influence on this money.

DR. HENDERSON: In identifying funds, we all talk about the fact that they come from private sources and public sources, with consumers paying a sizeable sum. As health costs continue to increase, how can we break down these different funding sources in a way that might further enhance non-white families receiving better care through greater accessibility? That's really the issue as I see it, the crux of objective number two.

MS. PILGRIM: I mentioned to you before when we were talking about neighborhood health centers and rural health centers that there's a need for both. When you start taking money away from neighborhood health centers to support rural health centers, what do you do? You're beginning to pull the rug out again, and you're pushing people back out of the system. I think that as new programs are developed money should not be taken from existing programs.

DR. DARITY: One of the things she's saying is that in order to have our budget balanced we move funds around. If we want a rural health center, we pull the financing from under the urban or the inner city center. There's no use thinking we're going to have improved and extended health care services and good preventive health services without more money. And to think that we're going to do it with existing funds is ridiculous. Maybe we should close down the Pentagon to get the extra money. I'm simply saying that the money we have now just isn't going to do it. We have to have more money. Simply shifting it around is destructive. Nevertheless, let's talk about some of the existing mechanisms. One is the financing of community health centers. There's special legislation for that.

A VOICE: I believe there's a need to become a part of the political system in each of our localities and at different levels within the states. Dr. Haughton yesterday discussed how he approached bringing about change. What he did can work for us in our localities. We must become a part of the political system. If it's a two-party system, then blacks can be in both parties. Regardless of party we're all working for the blacks in the community.

MR. ISAACS: Two things. In terms of short term kinds of financing, I think that has to be a mix of private and government funding.

DR. DARITY: Well, let's talk about what is being done now. Let's look quickly at the various mechanisms. First there's federal or public support, which is Medicaid, Medicare, etc. Then you have some of the mixtures of private and public monies. Do we need to go through and identify them? I think it's clear what they basically are.

MR. JOHNSON: They should be identified and labeled under Medicare, federal, state, private sector, etc. I think we need to name them.

A VOICE: We've got to identify first the needed service. For example, if we're talking about abortions being available, then we have to ask, what are the existing sources for financing and reimbursement? One is obviously private funds for those who have them; another is private insurance. But what about federal funds? They're very limited and vary by state. We need to say something about the existing financing and reimbursement mechanisms for low income women. We need to make a recommendation that such funds be available through Medicaid, or through private insurance or however we want to do it. I would opt for Medicaid myself. But I think we have to identify what the need is.

MR. WOODS: I would like to continue to address objective two. I feel that the problem is that black individuals do not have the raw data to show that there is a shortage of good health service. I feel that once we have the raw data, then we can go about securing the dollars. Right now the government is pushing the zero-based budgeting system. That is, they will no longer fund just organizations, but they will fund programs. If we had the raw data to show that abortion is a high priority and that health centers are not delivering quality health care, then we could sit down and write a proposal for an abortion program. We can write a proposal for prenatal care, because we have the raw data.

DR. DARITY: I understand you're saying that we've got enough data on the health status of selected communities.

MR. WOODS: That the data we have is second-hand data; it is not being secured by us, but is being secured *for us* by other individuals – white academics and research consultants. I'm saying that we have to start securing our own data.

DR. DARITY: In that connection, we need people who can deal with the hard sciences. One thing that we may want to say is that we who are here recognize the need to encourage blacks to get into health services research. We're going to have to develop these researchers. There aren't that many in the field.

MR. WOODS: Not only that, but once you get that type of data and you have programs set, those funds become restricted and the shifting of funds across program categories becomes very hard. If an organization is funded to deliver a certain service, the money is just for that service; it cannot be shifted to another service.

DR. DARITY: I agree with you. But I'm saying that is rigid because you have the information saying this is a need without the flexibility to shift money back and forth. This is an identified program. This is something that funds are made available for. They're to be used for that purpose only. Yes.

A VOICE: It seems to me there is no problem documenting the situation of black Americans. I can gather 15 volumes of documentation, and that would not get a program funded. The problem is not one of justification.

DR. DARITY: Well, then what is the problem?

A VOICE: I'd like to expand on that. We already know what the problems are. We already have the justification. After you get the data, the problem is that there is no black-controlled institution through which you can impact on funding sources. We don't have an organization. Education is not the simple answer, either. Suppose all black youth went out and got educated today in the allied health professions. Where are they going to go to work? They're going to go to work for white institutions that are getting the research grants, that are getting their programs funded, that are getting all the input. We get neutralized by the system. That's the issue.

DR. DARITY: Let's get some recommendations. What are we going to do about this issue that you brought up? What do you recommend?

A VOICE: We need a black health professional organization that is going to act as a trade association for the other black consulting firms or your neighborhood health centers that are primarily servicing black communities. Through that organization, we can send representatives to the agencies that make these decisions that impact on our health care. Until we have that kind of clout, we can't do anything except have these conferences and sit around and talk about the problem.

MS. HOWZE: I agree with the comment that the young lady made, but in addition to that, we need to have black researchers in those educational institutions doing that research. It has been my experience, at a predominantly white institution in Boston, that the kind of research that is done there often results in policy. And when you look around to see if minorities are involved in that research, invariably you do not find any. Next year, from my understanding, schools of public health are going to be involved in capitation grants. I think that's going to have a significant impact, because schools of public health are supposed to increase their enrollment. Is there any way of insuring that the increase will include representative proportions of minorities? I think we need to be about insuring that that increase is reflective of minority populations.

DR. DARITY: Well, the legislation definitely does not take care of that. It completely leaves health education out, which is very important in the black community. It's a very bad piece of legislation, as far as the minorities are concerned.

MR. WOODS: I agree with what she's saying; she hit it right on the head. When research is done, that research leads to policy formulation. For example, research revealed that between 1975 and 1976, close to half the female population of the State of New York had an abortion. Now that formulated a policy. If you look at those numbers, you will find that close to 80 percent of those people were women of color. Of that great number, you will find that close to 50 percent of those women were having dual abortions in one given year, which had a traumatic effect on child rearing and child bearing in New York State.

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A VOICE: It seems to me that the relationship between research and policy is getting mixed up here. Most research is used to justify policy, rather than create it.

DR. DARITY: I'm not trying to argue, but research is not always a tool to justify policy. It is quite often a tool to develop policy. It is both, and I don't think we ought to play down either aspect.

DR. HENDERSON: You have a strong point, but up to this time there's very little policy that has been based on *health services research.* There have been policies based on *clinical* research.

A VOICE: A notable example of good research was the work done on hypertension, which white researchers primarily carried out; they did an excellent job in researching hypertension among blacks.

A VOICE: I think data should be collected by black people. But after data is collected, there remain the problems of interpretation and utilization. This is where there has been a breakdown. Another problem we have is a shortage of people trained to do research. We have several black colleges who are serving black communities. Not enough money is going into these institutions to educate and train black researchers, or to allow the professors who are teaching in these institutions to do research. We need an allocation of additional funds to these black institutions to carry on research.

A VOICE: And it should be tied with services. That's another problem with research. It's often not tied to the delivery of services.

DR. DARITY: You can't always do that. Where it's possible, research should be tied to services. But one thing we have to understand is that if all research money gets tied to services, that policy would kill off a lot of good researchers.

MR. FOSTER: As I sit here, I see some issues that we need to redirect our attention to. Number one, are we satisfied with what the present system is? Obviously we aren't, or we wouldn't be sitting here. If we aren't satisfied, then obviously some changes are needed. And it's our responsibility to suggest those changes.

Let's take up a specific area: There are presently about 25 different national health insurance proposals; are any of these proposals acceptable to our community? If they're not, then maybe we should get involved in drafting one that is acceptable to us, which identifies the needs we have and the abuses that we experience. To carry that a step further, I

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think that we should get busy with the business of having an effective lobby that represents what our needs and feelings are.

A VOICE: I'd like to make one observation here. We shouldn't spend a great deal of time trying to analyze national health insurance bills here, because as Pete Fox said, national health insurance is about nine or ten years from now. We should come up with some serious recommendations as to what to do about the present. And then if you want to have a group to consider the future, this might be appropriate.

MR. McCRAVEN: Before we leave this area, one of the things that needs to be recommended is that blacks involve themselves in the development of these health bills and the various amendments to them before they get so far along. I agree that we can't analyze all the NHI bills right here, but national health insurance is something we ought to be involved in. So one of the things we need to say is that this conference should use its efforts to develop a mechanism for blacks to work through in achieving influence in the legislative process.

A VOICE: I want to recommend that the conference go on record as having a black health lobbying organization. But the one thing I want to emphasize is that that organization must take into consideration all *classes and levels* of blacks. I work with many Jewish organizations in New York. When they have needs and are supporting certain bills, they get that information out to the masses. One of the things black professionals have got to start doing is to work on all levels and classes, and not just in a closed shop.

MS. RIPPLE: I'm the Director of the Health Systems Agency for the three-county San Francisco area. I've listened to you today. I heard you talking about information and referral processes. I heard you talk about being part of a political process at all levels. I heard you talking about funding alternatives. I came here to find out about funding alternatives to improve the health care of blacks in our area. I did not hear you really address one topic that I think covers funding alternatives. That topic is the work of HSA's. In many areas HSA's are having problems. They're focusing in on cost containment of hospitals, because that's what the federal government demands. But they have a broader role, and they have responsibility, eventually, for reviewing all federal funds pertaining to health that come into an area. HSA's also have authority for appropriateness review and you need to interrelate with those agencies.

DR. DARITY: Thank you very much. Let's stop here, and be back here right after lunch.

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WORKSHOP IV
AFTERNOON SESSION

DR. DARITY: Let's open up the session for this afternoon. I don't think it would be worthwhile for us to talk anymore about what the problems are. Let's see if we can get together on some specific recommendations. Is this all right with you?

A VOICE: I want to make one observation. Less than a year ago I came out from California to attend a conference here in Washington related to these kinds of problems, but it was for the directors of minority-oriented health centers. We had a very good meeting, but I haven't heard anything since. I think the most important thing we can do is make sure that we just don't come here and talk and that's the end of it.

DR. DARITY: I hope I'm not overstating it, but this is one time I feel that there is a real commitment to get the report out and get it into the right hands. One of the things I asked when Expand asked me to participate was, "What are we going to do with the report?" And they said, "The purpose is to get us together so we can have a report that will really be influential." If we could now think about some recommendations, something that we can bring forward that can be put into action, I believe those recommendations will be listened to where it counts.

MR. RADEN: Everyone I've talked to at this conference has said that we lack an organizational structure to ensure that things happen for blacks in regard to health care. What I would like to see happen is that everyone at this particular conference make a commitment to involve themselves, and the group they belong to, to develop a viable black organization. Before we leave this conference today, we should set up a steering committee of maybe 15 to 20 people who will meet to develop a mechanism for involving all those people here who have committed themselves.

DR. DARITY: Let's have a discussion on that.

A VOICE: You're talking about putting together a steering committee from the entire group of participants here?

MR. RADEN: Yes. I think there are about two or three hundred people at the conference. Nothing gets accomplished with two or three hundred people. So I'm saying that we should develop a small working group to explore how we approach organizing to do policy planning for blacks.

A VOICE: The task force should also work to develop a mechanism for some permanency, some permanent organization.

DR. DARITY: I agree with you but first we might want to see how the other organizations already established fit in.

A VOICE: I can tell you categorically that as far as I'm concerned, the existing black organizations, by and large, have not met the needs of the black community. If any black organization takes exception to what I'm saying, then prove I'm wrong. But as far as I'm concerned, they haven't done anything and I think it's about time we took steps to organize ourselves.

MS. BERTRAM: I'm the Director of Health Education for the Central Maryland HSA. I'm new here, and you may say that I belong on the other side because I'm in health education. I'm particularly interested in health planning and policy development. A primary emphasis of a group like this ought to be how a small group of blacks, interested in the health care of blacks, can critically analyze the HSA legislation. This analysis should specifically address what the legislation means in terms of the health problems of blacks all over the nation. What does the health planning legislation mean in terms of the role of HSA's, in terms of implementation, monitoring, evaluation and allocation of funds; again with specific reference to blacks.

DR. HENDERSON: Let me act as facilitator here, just to review briefly what we've said so far; then we can take it from there and move on. I think we probably deviated from the program a bit, in that this morning's session focused on two main issues, the need to organize and the need to disseminate information. The service needs that were discussed were primarily related to the social modeling of health care prevention; that is, prophylactic programs – nutrition, family planning and abortion – the needs of the aged, and problems of stress-related conditions – alcoholism, drug addiction, etc. Those were the focal points of this morning's session. This afternoon we're talking again about the need to organize, the need to disseminate information. But what we don't have is information on what organizations are already in existence. Some of us know about the Brain Trust. Some of us know about other organizations that are functioning in other ways. Some of us know that black doctors did comment on national health insurance programs, and that black organizations somehow do say something about medical education funding. But they may not be saying what needs to be said. So maybe there's a need for this task force to focus on better communications. I think that's where we've gotten to at this point. We've also identified some agencies or superstructures under which we should work, one of which is the HSA, which is doing planning and policy now. We need to get involved with HSA's at every level, and also get involved in politics. We need to get involved with the Congressional Black Caucus, either through the Brain Trust or as individuals. We need to start letting our representatives know what we think about what's happening. We also need to get involved with black educational institutions and actually push them as sites for collecting data, and for generating the kind of data we need to support the kind of proposals we want to implement. Those are the kinds of things that we have come up with. I think we ought to take that and go the next step.

MS. WILLIAMS: It sounds like today and yesterday there has been identification of a need for primary care centers in existing communities, and for developmental funds for group practices that the HSA's propose as one of the best means of delivering care. I'm wondering if this body, the task force, or whatever develops out of this, could work to put more teeth into existing legislation such as Title XI, which is a joint HUD/FHA program, a mortgage guaranty program up to 90 percent for physicians within the community to join forces and build new practice facilities. There has never been one such project funded in the region that includes Los Angeles County. There is a group of ten physicians in that county who have been battling with these people for five years to get these funds. I'm suggesting that if an organization such as this would back these physicians in the community, it would be one action step.

It seems to me the other area that you were discussing was education, training and research. I'm suggesting that there are some OSHA funds for research and education. There ought to be somebody in the total group who has the expertise to write a proposal for an occupational and environmental health center for the people in a community to be trained in dealing with occupational and environmental health kinds of diseases, for facility development, and physicians training. That would be a way of helping people in the community in terms of employment, training, and preventive health care. This is an idea, a concept, that I am suggesting this workshop present to the total body.

MR. WINBUSH: I was here yesterday to hear Congressman Dellums. I would hope that we could go on record as supporting the bill that he introduced.

DR. HENDERSON: Can I suggest that we read that document before we support it? I agree with Brother Dellums on just about every point he makes, but I don't know what's written between the lines.

A VOICE: I would like to recommend that we develop a set of priorities on things we want included in any health legislation. Knowing that we have to make some trade-offs, we should prioritize what we want to include in any health legislation, and identify those things that we absolutely cannot live without.

DR. DARITY: Okay.

MS. SMITH: I'm Doris Smith from Philadelphia. There is a Congressional Bulletin, published daily, which describes all legislation introduced. All you have to do is write your representative and you'll get it. Frankly, I don't understand how you can function without knowing the legislation. Ron Dellums' bill has been in Congress for five years; to sit here discussing the proposal without having read it is absurd.

DR. DARITY: Let me give our facilitator some time to go back quickly over what has been said.

DR. HENDERSON: In summary, initially we had four objectives. Looking at objective number one, to discuss the need for better health services within black communities, we focused primarily on services that were either clinical or preventive. We didn't comment too much on the clinical models, because we felt that research supported clinical intervention, and that there was good evidence that the clinical models would progress without us. But on the preventive model, we discussed the fact that we have a serious need for preventive health services – nutrition, counseling, health education, family planning – and for a focus on the problems of the aged.

Next we chose to deal with the idea of organizing ourselves, and to start to share information on a national and regional basis; to develop a task force by voluntary assignment; to work on specific problems that could be identified as major issues. In concert with that objective, there was a recommendation made that we identify those health problems crucial to non-white communities and that we make sure that those problems are addressed in any future health legislation.

We talked about existing organizations under which we can work. We identified the HSA, which is currently in effect as a primary target site. We said that the Congressional Black Caucus, which is a vocal unit already in existence on Capitol Hill, had an appendage, the Health Brain Trust. We should learn more about the Health Brain Trust and make an input to that Brain Trust. We also focused on the need to demand funds for black institutions to do research about black people and present data that can be used as ideas for proposals to help fund our own programs and formulate health policy. We've talked about the need to identify existing alternative methods of health care delivery and organization of existing services, and to support those services. We talked about the existence of Occupational Health funds that could be used. They have proposals to develop centers for occupational health education, through which we could disseminate information to our communities and help increase awareness. I wrote down a suggestion, and the group can check this out; that Expand Associates or a comparable group develop a national media program to focus on preventive health needs and the need for political awareness and organization of non-white people in this country. I think that goes in concert with the last proposal. It was recommended that we support Congressman Dellums' bill. There was also information provided us that the bill is five years old, and that we really should have been doing our homework as role models – health professionals, and not sitting here saying that we don't know what the bill is all about. Is there anything that I left out?

MS. SASPORTAS: I'm with the Massachusetts Hospital Association. I don't have a particular objection to the recommendations, but I'm very concerned about the fact that you haven't addressed any of the financing issues, including the whole concept of the prudent buyer, which Blue Cross is advocating. This concept says that only the cheapest services can be used. Thanks to economy of scale, the prudent buyer idea favors the teaching hospitals. Small community hospitals will be pushed out. That hasn't been dealt with at all in this conference. I'm concerned that all afternoon we haven't actually dealt with the financial issue.

MR. AARONS: I'm the editor of "Resume," a publication of the National Association of Health Services Executives. I have one recommendation. There is a critical need for a clearing house, so that information that we need can be disseminated, shared and utilized. A black lobby and a black clearing house for health care information – both are urgently needed.

A VOICE: A major source for reimbursement of services to the black community is Medicaid. Medicaid is inadequate, in terms of both curative and preventive therapy. What I would like to recommend is that we do not allow any new health service or financing plan to be adopted under the present Medicaid reimbursement formula. Reimbursement plans need to be modified to address some of the needs that are emerging from the data banks, such as orthodontic care, vision care, and the need for adolescent services. If you look at Youth Corps statistics, you will find that black teenagers between 12 and 18 or 19 are sick. And many of the services they need, Medicaid does not pay for. We need an adequate financing mechanism, and Medicaid is not it.

DR. DARITY: Let me just say one last thing. We've talked about curative medicine. We've talked about financing. We've talked about prevention. Do we have any specific suggestions on procedures for financing preventive medical care?

DR. HENDERSON: I suggest that we think about a 25-cent tax on every bottle of liquor and every package of cigarettes, and that we use the funds to finance research in diseases that are caused by these poor health habits.

A VOICE: Addressing the issue of financing, and modifying the present financing structure, the only legislation that might have a significant impact in the near future is national health insurance. Going back to the issue of prevention, within a national health insurance program, such areas as health education and nutrition education should be considered as basic benefits. That way you address both issues, prevention and financing.

DR. DARITY: All right. What about the lobbying group?

A VOICE: I did some work on this at the beginning of the year. The first thing we need to do is identify all the black health organizations and their leaders, and develop a mailing list. Then we need a staff. We need some administrators and some statisticians. We also need some legal and political expertise, to be able to develop our own legislation. We have to have black researchers, and we need some kind of headquarters.

I suggest that as a start we identify who we are, who among us is qualified or eligible or responsible enough to be able to work with us and get our staff together. I also suggest that we come up with some means of getting money. We need some funding sources. We need supplies, we need an address – a headquarters. And we need some regular meeting times.

DR. DARITY: We've talked about a task force, a small group of people who would get together and try to come up with something. Would you like for them to look at this? I think what you're saying is right. All these things are needed. I was hoping that we could see a sense of volunteerism and maybe some contributions from black people instead of going to NIH all the time. We're going to have to do this ourselves.

A VOICE: Volunteers are fine. But I volunteered a year ago, and I didn't have 13 cents for the first stamp. That's how far volunteerism goes.

DR. DARITY: When I talk about volunteerism, I'm talking about volunteering some cash on the line.

A VOICE: The financial commitment should come from the black professional organizations. Each organization should put a certain amount of money into its budget to do what the sister just described.

DR. DARITY: Okay. We're going to have to close down. Let's try to hear somebody who hasn't said anything at all.

DR. DEBOSE: It seems to me there are many good recommendations here. But sometimes we come to a conference and I don't think we know what's going on. The National Association of Health Services Executives has an office that they share with the National Association of Community Health Centers at 1645 I Street in Washington. Those groups are doing some lobbying. They have a publication. They've been very effective. So it seems to me that the task force that you're talking about getting together here might want to contact one of those two groups, who are already doing lobbying, who already put out news releases, who already have contacts.

DR. DARITY: That's exactly what this task force is going to try to do. That's the purpose of it. That was the last statement; we're out of time. There will be no more today.

(The meeting was adjourned at 3:40 p.m.)

REPORT OF CLOSING PLENARY SESSION

MODERATORS

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CLOSING PLENARY SESSION

PRESIDING: Theodis Thompson and Paul Cornely

DR. THOMPSON: We, again, would like to say that you have been an excellent audience and hard workers in the workshops. During this closing session, Dr. Cornely and I will be reading workshop recommendations as they have been presented to us by each group. So, if there are any questions afterwards that need clarification, you may get them from the workshop leaders and facilitators. I might add that the proceedings of this conference will contain a synthesized list of the recommendations made from all four workshops. Workshop Number I is National Health Insurance: When and How and Who or What? The leader is Mr. Everett Fox and the facilitator is Mr. Jim Crawford. I am going to read exactly what this group has said. *There is a need for national health insurance with the following characteristics: it should be comprehensive, universally accessible, and there should be no deductible requirements, co-insurance or co-payments.* Is that the first recommendation from Workshop I or is it just a premise under which the group was working? Is there a clarification on that Mr. Fox?

MR. FOX: Yes, it is a premise.

DR. THOMPSON: Okay. Then, the recommendations would be: *(1) that the traditional health care delivery system needs to be changed to guarantee access and quality to all; (2) that inadequate data exists upon which to base objective recommendations, and that such a data base should be established. Initial efforts should include the coordination of all existing data in federal agencies and private organizations; (3) that there be black involvement at all levels of health care planning; and (4) that there be a follow-up to this conference with the intent of establishing an educational drive about the pros and cons of national health insurance.* Those are the summary recommendations of Workshop I. I might add that we should define "involvement" as stated in recommendation 3.

Workshop Number II dealt with the cost containment strategies and their effects on current patterns of health care delivery. The leader for Workshop II is Dr. Gerald Rosenthal and the facilitator is Mr. Richard Lowery.

Following are the recommendations from this group: *(1) that cost containment initiatives and existing regulations should take a long-term view; that is, investment in long-term cost reductions, including prevention should be on curative issues of a curative focus, linkage of health care policy to social services policy, such as nutrition, housing,* *education, et cetera; (2) that the federal government's laws, rules, regulations and guidelines should focus on the allowance for more effective use of non-doctor health care professionals, health care education of consumers, the use of low-bed occupancy hospital beds by HMO's and health plans; (3) that the federal government regulations and guidelines should require appropriate safeguards to protect private institutions and practitioners from shifting costs from themselves to municipal, rural and public institutions. This should include greater formula equalization for cost reimbursement between private and public hospitals for the care of Medicaid and Medicare patients, greater flexibility of standards among hospitals to allow selected exemptions based on patient mix and the resulting facility utilization, and states should hold public hearings before changing state rules and regulations, et cetera, which affect access to health care; and (4) that all aggregate savings from cost containment and education be refunneled into health care services.* We might want a clarification on that last recommendation. Perhaps we can get it from the facilitator after this session is over.

DR. CORNELY: Workshop Number III is concerned with health planning strategies in the black community. The leader is Fred Adams and the facilitator is Steve Wilson. This workshop had a total of some 14 recommendations. The facilitator and the person who was there looking and listening to the recommendations selected the five which appeared to have a lot of emotional attachment and substance to them. But all 14 are good, and we're giving you just five of these: *(1) that the seven amendments suggested for Public Law 93-641 be enacted to allow consumers to have the legal right and persuasive authority to control health planning policies in their service areas; (2) that a national consortium of black health concerns be established. I believe this is addressing the fact that, at the present time, there are a number of black groups which are interested in health activities, and this would make it possible to bring all of these together; (3) that levels of political astuteness on the part of members of HSA and SHCC boards and staff to mobilize consumer interest and gain enhanced black representation on these boards be increased; (4) that state medical facilities' plans be made inclusive of the particular needs of each community; and (5) that Howard University and Meharry Medical Colleges become centers of consultantship on black health concerns commensurate with the intent of Public Law 93-641.* These are the recommendations which appear to have a great deal of interest.

Workshop IV has to do with improving health services for blacks through alternative health financing schemes led by Bill Darity with Donald Henderson as the facilitator. These are provided to us in the order of priority by the facilitator: *(1) that a black health lobby is needed. This conference group can serve as the nucleus of such an organization. The registration list of participants can serve as the initial mailing list; (2) that a data base* *and communications systems which will be needed by the lobby be established; a newsletter managed by Expand or some similar organization should be instituted at once; (3) that a potential source of quick money in substantial amounts be sought for use in future preventive programs. Perhaps a tax of $.25 on every bottle of liquor or pack of cigarettes sold could serve as such a source.* Now, please don't rush out now to try to corner the market (laughter). As soon as I read this, I sent out some telegrams myself (laughter). That's Number 3; and *(4) that the national health insurance model of financing health care is the basic model which organized black health professionals should support. The Medicaid reimbursement employer-based and tax credit models should specifically be opposed.* These are the four recommendations in the order of priority which the facilitator selected out of the conference summary. Now, we have read for you and to you the recommendations; we should first ask, on Workshops III and IV, whether there are any modifications that you might want to make, either from Fred Adams, Steve Wilson or from Darity or Henderson.

MR. ADAMS: I have none.

DR. CORNELY: Are there any others from these two selections?

DR. HENDERSON: My name is Donald Henderson. There are a couple of areas of clarification; one, on the recommendation for the tax to be levied on cigarettes and liquor is that those monies be used to pay for preventive service, as well as for ongoing health services for people who have diseases associated with the usage of cigarettes and alcohol. The other point was that, out of the idea of developing a black health lobby, that a group from this organization convened for the past 48 hours, would voluntarily serve as a task force which would be the nucleus for developing that lobby. And we had one volunteer, a community health educator from North Carolina who said that she would donate her time. If there are other people who feel the same inclination, this should be an excellent time to do so. I would also welcome any clarifications from the people who participated in Workshop Number IV, since there was a lot of heated discussion.

MR. McCRAVEN: Will all of the recommendations be printed?

DR. HENDERSON: The question is: Will all the recommendations be printed? Do you mean the ones that were read or the ones made in the workshops?

MR. McCRAVEN: The ones that were made and weren't read.

DR. HENDERSON: The ones that were made that were not read. I cannot answer that question. Will all the recommendations as they were made in the workshops be printed, including those that you have selected and those that have been deleted?

DR. THOMPSON: Yes, all those that are legible and clear will be (laughter).

MR. McCRAVEN: Relating to the one on prevention, I think I sensed the determination of the body of establishing a policy of promoting prevention as we go back to our communities and in our agencies. So, it's much stronger than simply supporting a tax measure, but starting today to move towards preventive approaches.

MR. RANGE: I would like to make a comment, if possible, on one of the recommendations. One of the recommendations was that out of this group there would become a movement towards an effort to establish a lobby for issues as they relate to health for black folks in America. I would like to suggest that the body consider the feasibility of a coordinated relationship with other existing organizations that are, in fact, doing some of those activities now, that are also on the Hill dealing with a lot of political issues for black folks as it relates to health. One example would be the National Association of Community Health Centers. The more we form individual types of groups, rather than collectively banding together for that purpose, we may be diffusing an effort where we can move positively and constructively as one united front. So, in numbers we have power; in small individual groups, I wonder how much power we do have. That's just a suggestion.

DR. CORNELY: I would like to make a comment on that statement because I think that the recommendations which have been presented – have not presented the mechanism for doing them. I think that all of us have the responsibility as role models to go back and to determine how we can do some of these things. And, actually, the suggestion that has just been made is one that appears to be important for another conference – or, the beginning of an approach. There are a lot of black groups that are isolated all over the place. There is the Caucus of Black Public Health Workers. There is the Caucus of Black Social Workers and so on down the line. It appears to me that these groups need to be brought together, as was suggested, to coalesce and to really develop an important force in our communities and in the country, as a whole. I would hope that these recommendations can be sent to all of those groups with the suggestion that this will be a next step in terms of our approach to the problem.

MR. CRAWFORD: I'm Jim Crawford with the Committee for National Health Insurance, and I was facilitator with the first workshop today. One of the important points we brought up was the need for an educational drive on national health insurance, and I see that, in Workshop Number IV, you came up with the idea of a black health lobby. It seems to me that, in the interest of working in a coalition effort, we would be wisest to combine the two; in other words; to form the black health lobby and run the educational bit on national health insurance through that. I want to put that forth as a recommendation.

MR. BERRIEN: Charles Berrien from NIMH. One of the things that keeps popping up is that all of the issues that have been addressed and talked about here a small group of us have been working on since last December. Out of the 1976 W.E. DuBois Atlanta conference, there was some concern about the fact that blacks are not involved with health policy development, et cetera. So, over the past months since then, a group of us varying from eight up and down have been meeting in different locations around the country, and we have the nucleus for an organization of the type that you are talking about. What I would like to do is make the minutes from two of those meetings available to the people who have participated in this conference, with the idea that you would become involved with us in hopes of eventually crystalizing just the kind of organization that you are talking about.

One of the issues that you were just discussing, the lobbying issue, which Denise Williams volunteered her services for, also came out of this same situation in Atlanta. And she is involved with this. I just wanted to make it known that there is an embryonic thing happening that we would like for you to participate in.

DR. CORNELY: Thanks very much. Pauline Miles, would you want to make a comment on this?

MS. MILES: Charles Berrien has made reference to a small working group that's been sort of struggling since last December. We had attended a meeting that was sponsored by the W.E. DuBois Institute in Atlanta and, faced with some frustration about what do we do about the status of black health here in the United States, we decided to try to generate some interest and develop a momentum for forming a consortium of black health organizations or coalitions that currently exist here in the United States, and there are several. One of the first things we tried to do was inventory who those existing organizations were and where they were located. We met, as you know, in January, at the National Medical Association National Office. They had invited us to use their building. We discovered, from about 18 people who attended that meeting, that there was substantial interest and support in the whole concept or notion of developing a consortium of some kind. It was during that meeting that we also discussed the genesis of this conference which Reid Jackson, at that point, already had moved forward from an idea in his head to paper.

Another major meeting of the Planning Committee was held in March at Michigan State University, and, at that meeting, a major set of strategies was developed in the areas of health manpower, health services development, health services to blacks in the military and in prisons; a whole set of agendas and priorities were developed. The problem that we have faced with the Planning Committee is that all of us work for a living. And, at this point, it has been a volunteer activity. Each one of us has accepted a specific set of responsibilities for getting out mailings, telephone calling, meeting and that kind of thing. Reid Jackson of Expand Associates offered us his office in Silver Spring to use as a headquarters or a collection center for mailing and that sort of thing, and we have met at his office twice. But when one has to spread out what should be a formalized staff, it becomes very difficult when things are being done on a volunteer basis.

Some members of the Planning Committee met last night. We were kind of discouraged because our communication network has not worked as well as we thought it would. But, nevertheless, we agreed to keep trying. Let me assure you that we are not attempting to suggest that everything relate to what we have done. We are just indicating that some work has been done in this area.

All of the organizations that we have inventoried involved, for example, the National Medical Association, the National Dental Association, the Student National Medical Association, the National Association of Black Nurses, the National Association of Black Psychologists, the National Association of Community Health Centers, the National Association of Health Services Executives, and the National Urban League. There is a whole array of official national minority-oriented organizations, plus individuals, who attended the meeting in Atlanta, plus students. And, the list has been growing. We would like to make copies of the minutes of those first two meetings. It would give you background in terms of what it is we've tried to do and who are the people who have been involved. We would hope that, perhaps, this initial effort could be built on.

The other suggestion that I would like to make has to do with Therman Evans. It seems to me, given the kind of person that Therman Evans is, a health educator, a health researcher, he represents, to me, a very unique type of leadership. I'm sorry I didn't think of this before, but it seems to me that, given Therman's background and understanding of health manpower development, given his understanding of needs and what our weaknesses are as a group, that he might very well represent some type of leadership that we could tap in terms of strengthening this activity. And, then, of course, his very important position with Operation PUSH, I think gives him the kind of credibility that one needs when one is trying to start a new organization. So, I suggest Therman Evans as a person who might represent some leadership in moving this whole activity forward.

DR. CORNELY: I would like to make two observations because I think that we should get, really, down to the nitty gritty. At lunchtime, of course, we were all carried away by Therman Evans, and we gave him a standing ovation. I have seen this done before by black groups that get carried away. And then, when they leave, you don't hear too much about it. It seems to me that the time has come that we've got to put it on the line if we are going to do anything. I would hope that with the suggestions Pauline and Charles and all of us have made here, that this will become a reality with us. The second thing that I would like to say is this, that too many of us don't like to relinquish the little power that we may have in our individual organizations and, therefore, it's always difficult to try to get a coalition together to work together. These two are tremendous handicaps, and I think that the time has come. This is it. You know, black people are in bad shape. They don't have jobs. There are people here right now with education and training and experience who are looking for work. You can imagine what it's like in Detroit, in Cleveland, in other places where people don't have many skills. The Business Review came out three weeks ago and said that, in a technological society such as ours, black people are expendable. And this is the way it is. I think that we have to move quickly and move forward with aggressiveness and dispatch.

DR. THOMPSON: Before we close the session, are there any more recommendations that could be made that may not have been made in the workshops? Does anyone have further comments they would like for Expand to consider in terms of its dealing with the issues at hand and toward us talking about developing a national health policy which will relate to black America?

MS. CUFFIE: My name is Lola Cuffie from Brooklyn. I am a consumer advocate. I would recommend that things that we have discussed today be put into practice and to put our dollars on the line. No organization can operate without money. We get carried away with nice speeches, but none of us want to put our hands in our pockets and contribute. And until black people stop looking for handouts and are willing to pay the cost, we're not going to get anything. I'm tired of going to these conventions and hearing all these beautiful talks. I've been up here a long time. I'll be 75 my next birthday. And if I, a widow, am willing to put her hands in her pocket and contribute something that will help the future generation, then I think everybody else should. Thank you.

DR. THOMPSON: Right on. Not only food for thought, but words and thoughts to be consumed and eaten.

MR. CLARK: I would like to take the opportunity for me and for everybody in the room, to say publicly, "Thank you" to Expand Associates, and to you two brothers, Dr. Cornely and Dr. Thompson. I hope that you will distribute the list of people who participated here because the one thing that was so nice, is to see that there are so many black folks all over the country who are so dynamite and, if you sit among us, we feel that we are very dynamite. Blue Cross couldn't put as many dynamic people in the room as we do. Okay. So, I just want to sing praises to all of us, no matter what level we struggle on.

I want to go away with making one other recommendation, that we take all the energy and the reaffirmation of ourselves that we see in each other and go back to that local level and continue to struggle. The folks from HEW ran down so many statistics and told us that we are sick and still getting sicker. And you notice how we all get conditioned over time. Ten years ago, you'd have known what I'd have said. But the feeling is here. We have gotten so cerebral in this conference, that they ran statistics down to us and we sat there and nodded and nodded. There are those of us who will continue to move, as the sister said, on the national level, but you'd better believe it's digging into the trenches where we all are individual – state, local, HSA's and so on. Let's encourage each other. I encourage the brothers who care. Thank you.

DR. THOMPSON: There is one other announcement. Dr. Lear wanted to make an announcement on something.

DR. LEAR: I am Walter Lear. I am representing the Medical Committee for Human Rights, an organization with a history of 14 years in the struggles for human rights and health rights. We are, again, very active in the APHA convention this year, and we wanted to bring to your attention – and we very much appreciate this opportunity to do so – the fact that we are sponsoring a demonstration tomorrow at the Supreme Court on the Bakke case, and that we would like to urge you and all of your friends who are concerned about the very, very severe consequences of the decisions that will be made by the Supreme Court for jobs, for blacks and other minorities, as well as for the general cooling effect a negative Supreme Court decision might make in the whole human rights area. I have some of the flyers for the demonstration tomorrow. I also have flyers for a national conference on the Bakke case which will be held November 19th and 20th at Howard University, College of Medicine. I have a few copies of our pamphlet on the Bakke case, which has been noted by a number of experts in the field as being a very useful one, that's available for $.50 either here – and, if I run out of copies here, the Medical Committee for Human Rights is in Booth 400 in the exhibit hall, and we would be very glad to provide more copies of this pamphlet. We will also have more copies of this flyer on the Bakke Conference November 19th and 20th at Howard.

I can't help but add my agreement with some of the views expressed here that conferences are very useful, planning is very useful, but the time has come for other kinds of action. And we are trying to offer you that opportunity as well. Thank you very much and good luck.

DR. CORNELY: We are going to have that available. I think that one of the things that we can do tomorrow is to show that we can be there. I mean, this is the first possibility of action after this conference; go out there tomorrow at 1:00 o'clock. I'm going to be there, and I want everybody to be there.

Now, I think that we are going to close at this particular moment of time. I would like to turn the microphone over to Reid Jackson, our illustrious President and the man who has done everything for quite a while and deserves a hand of applause. Let's give an ovation for him.

DR. JACKSON: I am at a loss for words, and that's unusual for me. I say that because I am overwhelmed at the enthusiastic participation of all attendees. As far as Expand is concerned, we have really worked hard on this conference to bring something together so that people of color who are suffering, as we all know, can mobilize as a unit and discuss health policy. Now that this conference is coming to an end, let's just not go home, and talk about working at the local level – let's go home and work at the local level, to better inform our peers about how the future of health care in America for blacks might be improved with their input and unified support.

Pauline Miles mentioned something about establishing an active national consortium, and I agree. However, I think that it is time for all of the fractionalization that goes on among the groups concerned with minority health care to stop. It doesn't make any difference who leads such a group, the fact is we need a nationally organized constituency. So let's not let our positions as directors of various health programs interfere with our efforts to mobilize. We've got to put our money where our mouths are. We've got to get together and organize, otherwise all of the discussions and recommendations that have been made here over the past two days will be meaningless.

So, there are two things that I would like to see as the outcome of this particular conference: one, that we get together and mobilize. Make yourself a viable voice so that the administrative and governmental officials who were here yesterday can be made to put their money where their mouths are. Now, they have said, "Bring me your recommendations and we will see how they can be implemented." It is the intent of Expand to do

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just that. We're going to clean them up some, because there is some overlap from one group to the other. Once this has been completed however, we'll be knocking on the doors of people like Joe Onek and Ted Kennedy, who have said they welcome such input. The second outcome I'd like to see is for you to write a letter back to us – it doesn't have to be long; two or three lines will be sufficient – saying that you support the recommendations which were made. Now, you really won't get a chance to read the synthesized copy prior to our contacting the various officials, but you will just have to trust that we at Expand will do a proper job. Our address is in the conference folder. Let us hear from you.

At next year's conference – and I say "next year's conference" because I do want this to be an annual affair – we can see what has happened to the recommendations made here today. Expand will report on that. Again, the two things I ask of you *(1) mobilize and establish a national consortium, and (2) write to Expand to voice your support of the recommendations you made at this conference.* I believe these two things can be done. A good place to start with number one is to work at your home base, to increase the awareness of those concerned with the health care of blacks about policy, planning and financing. It is time now for blacks to start making some of the rules as opposed to trying to change them after they have been made. That's what this whole conference has been about. I am glad that you have come and, hopefully, you will be able to pass the word along to others that, next year, the conference will be bigger and that it should not be missed. I really don't have anything else to say but thank you for your participation; I hope you have enjoyed this conference as much as we at Expand have enjoyed sponsoring it.

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16. Abstracts

This conference provided a forum for identification, discussion and recommendation of alternative policies and approaches to the involvement of blacks in the health decision-making process in the United States. Discussions were held regarding the State of Health Policy in America; Formulation of Public Policy: Process of Implementation; The Black Administrator in the Health Policy Arena; and Problems and Issues in the Financing of Health Care. Workshops were conducted on National Health Insurance; Cost Containment Strategies and their Effects on Current Patterns of Health Care Delivery; Effecting Health Planning Strategies in the Black Community; and the Improvement of Health Services for the Black Community through Alternative Health Financing Schemes. The recommendations developed in the four workshops have been presented to the appropriate committees of Congress and administrative officials for consideration in the development of future health legislation.

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